

**PATIENT REGISTRATION INFORMATION:**

Patient name (last/first/MI): \_\_\_\_\_

Maiden name/Alias: \_\_\_\_\_

Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Patient SSN: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male/Female

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Country of Origin: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Email: \_\_\_\_\_ Race: \_\_\_\_\_

Parent/Guardian (if patient under age 18) \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

**PATIENT EMPLOYMENT:**

Employment Status:  full-time  part-time  self-employed  retired  not employed

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**INSURANCE INFORMATION:** (be prepared to present your insurance card to clinic staff at every appointment)

**Primary Insurance Information:**

Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Policyholder Gender: Male/Female **Policyholder DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policyholder Employer: \_\_\_\_\_

Address: \_\_\_\_\_

**Secondary Insurance Information:**

Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Policyholder Gender: Male/Female Policyholder DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policyholder Employer: \_\_\_\_\_

Address: \_\_\_\_\_