PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

Patient Name: (First) ______________________ **(Last)** ________________________________ **(M.I.)** ____

Date of Birth:(MM/DD/YYYY) ____________________ **SSN #:** ____________________ **SEX:** ☐M ☐F

Address: ____ **Apt/Unit #:** __________________

City: ______________________________ **State:** _________________ **Zip Code:** _____________

Home Phone: _________________ **Cell Phone**: _____________________ **Work Phone:** ________________

Email Address: ____

Marital Status: ☐SINGLE ☐MARRIED ☐PARTNER ☐ DIVORCED ☐WIDOWED

Preferred Language: __________________________ **Religion:** ___________________________

Employment status: ☐EMPLOYED ☐UNEMPLOYED ☐RETIRED ☐CHILD ☐ STUDENT ☐ DISABLED

NOTIFY IN CASE OF AN EMERGENCY:

FIRST NAME: ______________________________ **LAST NAME:** ______________________________

Contact Phone Number: ________________________ **Relationship to Patient:** _______________________

GENERAL INFORMATION:

Race: ☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Other ☐ Prefer Not to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Answer

RESPONSIBLE PARTY IF PATIENT IS A MINOR OR HAS A LEGAL GUARDIAN:

Name: _____________________________________ **Relationship to Patient:** __________________

Address: _____________________________ **City:** ___________________ **State:** ________ **Zip Code:** _____

Phone number: ________________________________

SIGNATURE OF PATIENT/ GUARDIAN: ______________________________________ **DATE:**____________