



**Patient Registration Form**

**Date:** \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Suffix: \_\_\_\_\_

Preferred pronoun: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

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

**Physical Address (if different from mailing):** \_\_\_\_\_

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

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

Work Phone#: \_\_\_\_\_ Ext: \_\_\_\_\_

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

Patient Date of Birth: \_\_\_\_\_

Patient Sex at **birth:**  Male  Female

Patient Sex/**Identifies as:**  Male  Female  Transgender  Non-binary/Non-conforming

Patient Ethnicity: \_\_\_\_\_ Patient Race: \_\_\_\_\_ Patient Language: \_\_\_\_\_ Declined: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_

Person Responsible for Bill: \_\_\_\_\_ Relationship: \_\_\_\_\_

Responsible Party Date of Birth: \_\_\_\_\_

Responsible Party Contact Phone#: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_ Emergency Contact Phone #: \_\_\_\_\_

Marital Status S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_

Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Declined: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Retired: \_\_\_\_\_ Unemployed/Homemaker: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Policyholder: \_\_\_\_\_

Policyholder relationship to patient: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policyholder: \_\_\_\_\_

Policyholder relationship to patient: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**If this is a Workers' Compensation injury:** provide claim information to the front office staff