Patient Registration Form

☐ New patient registration
☐ Update of current patient demographic information

Demographic Information

Patient Name: _____ **Today's Date:** _____

Street Address, City, State, Zip Code: _____

Guarantor/Responsible Party/Name of Insured (if different than above): _____

Social Security Number of Responsible Party/Insured: _____

Date of Birth of Responsible Party/Insured: _____

Address of Guarantor, if different: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone #:** _____

E-mail Address: _____ **Spoken Language:** English Spanish Other

Date of Birth: _____ **Social Security Number:** _____ **Gender:** Male or Female

Marital Status: Single Married Separated Divorced Widowed **Name of Spouse, if applicable:** _____

If child, please list the name of the custodial parent/guardian: _____

Employer: _____ Part-Time Full-Time Retired

Occupation: _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone #:** _____

Referring Physician Name: _____ **Phone #:** _____

Primary Care Physician Name: _____ **Phone #:** _____

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing X to communicate with these entities regarding your healthcare and treatment)):

- ☐ Referring Physician
- ☐ Primary Care Physician
- ☐ Other Physician: _____
- ☐ School: _____
- ☐ Family Member(s): _____
- ☐ Other: _____

How did you hear about us? (*Please check all that apply*):

_____ Phone book	_____ Sign	_____ Google	_____ Health Fair
_____ Family Member	_____ Doctor	_____ Direct Mail Piece	_____ Open House
_____ Website	_____ Friend	_____ Newspaper	_____ Facebook
_____ Yelp	_____ Other: _____		

PLEASE COMPLETE OTHER SIDE OF THIS FORM.
WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.