



Patient Registration Form

Today's date:	Primary Care Physician:	Referred By:
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PATIENT INFORMATION

Last Name:	First:	Middle:	Suffix:	Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number:				Marital Status (circle): Single / Married / Divorced / Separated / Widowed	
Mailing Address:			City:	State:	ZIP Code:
Home Phone:	Work Phone:		Cell Phone:		
Primary Language:			Email:		
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Multiple <input type="checkbox"/> Decline				Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Decline	

EMERGENCY CONTACT

Name:	Relationship:	Home Phone: ()	Work Phone: ()	Cell Phone: ()
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INSURANCE INFORMATION

Primary Insurance (Carrier, ID #, Group #):	Secondary Insurance (Carrier, ID #, Group #):
Primary Subscriber Name and Birthdate:	Secondary Subscriber Name and Birth Date:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

RELEASE OF HEALTH INFORMATION

Is it okay to leave messages on your phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it okay to discuss your health information with another person? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
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ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I understand that it is my responsibility to notify the Center of any changes to this information.

Patient/Guardian Signature

Date