Patient Registration

PATIENT INFORMATION

Last Name (Legal)	First Name (Legal)	Middle Initial	Preferred Name (Optional)

Date of Birth	Social Security #	Marital Status (Legal)	Gender at Birth
		☐ Single ☐ Married ☐ Widowed ☐ Partner ☐ Divorced/Separated	☐ Male ☐ Female

Street Address (with Apt. # if applicable)	PO Box	City	State	Zip Code

Home Phone #	Cell Phone #	Employment Status (Check all that apply)	Employer Name
		☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Unemployed ☐ Student ☐ Military - Active Duty	

Contact Preference	Best Time to Contact	Employer Phone #
☐ Phone Call→ ☐ Home ☐ Cell ☐ Text Message ☐ None	☐ Morning ☐ Afternoon ☐ Evening	

Email Address (required for patient portal access and message reminders)	Preferred Pharmacy

Race	Gender Identity	Sexual Orientation	Are you a migrant or seasonal agricultural worker?	Ethnicity
☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other/Pacific Islander	☐ Male ☐ Female ☐ Transgender Male (F to M) ☐ Transgender Female (M to F) ☐ Other ☐ Choose not to disclose	☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose	☐ Yes ☐ No **Are you a US Veteran?** ☐ Yes ☐ No **Are you homeless?** ☐ Yes ☐ No	☐ Hispanic/Latino ☐ Not Hispanic/Latino **Primary Language Spoken** ☐ English ☐ Spanish ☐ Other _____ ☐ Interpreter Needed

INSURANCE INFORMATION (We will need a copy of your insurance card(s))

Primary Health Insurance	Secondary Health Insurance
Health Insurance Company	Health Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other _____	Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other _____

Primary Dental Insurance	Secondary Dental Insurance
Dental Insurance Company	Dental Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other _____	Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other _____

Primary Vision Insurance	Secondary Vision Insurance
Vision Insurance Company	Vision Insurance Company
Name of Policy Holder (if different from above)	Name of Policy Holder (if different from above)
Policy Holder's date of birth (if different from above)	Policy Holder's date of birth (if different from above)
Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other _____	Policy Holder's relationship to Patient (if different from Self) ☐ Spouse ☐ Parent ☐ Other _____

EMERGENCY CONTACT (Must be someone other than yourself)

Emergency Contact Name	Phone #

Legal Relationship to Patient? ☐ Spouse ☐ Parent ☐ Child ☐ Other _____