Patient Registration Form

Today's Date:

Patient Information			
Last Name:	First:	Middle:	Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower ☐ Other	Spouses Name (If applicable):	Patient's Date of Birth:	Preferred Language:
Address:		City:	State / Zip:
Email Address:	Cell Phone	Home Phone	SSN
Preferred Method of Contact: ☐ Phone ☐ Email ☐ Text	Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino ☐ Native Hawaiian / Pacific Islander ☐ Caucasian / White ☐ Other		
Work: ☐ Full-time ☐ Part-time ☐ Not Employed		School: ☐ Elementary ☐ Middle/High ☐ College/Tech	
Occupation:	Employer:	Address:	Phone:
Living Situation: ☐ Lives with Family ☐ Lives Alone ☐ Lives in a Facility			
Emergency Contact:	Phone:	Relationship:	Family Physician:
Pharmacy:	Location / Phone	Date of Last Exam:	

Person Responsible for Account (if other than self):		
Name:	Relationship:	Date of Birth:
SSN:	Employer:	
Insurance Information:		
Primary Medical Insurance:	Policy Number:	Group Number:
Policy Holder:	Relationship:	Date of Birth:
SSN:	Employer:	
Secondary Medical Insurance:	Policy Number:	Group Number:
Policy Holder:	Relationship:	Date of Birth:
SSN:	Employer:	
Tertiary Medical Insurance:	Policy Number:	Group Number:
Policy Holder:	Relationship:	Date of Birth:
SSN:	Employer:	

Vision Plans	☐ VSP	☐ Davis	☐ Superior	☐ Other:

How did you hear about us? ☐ Family / Friend _____ ☐ Internet ☐ Insurance ☐ Physician Referral ☐ Other_____

By signing this document, I confirm my information to be correct.

_____ Employee Initials_____

Signature