PATIENT REGISTRATION FORM

Today's date: _____

☐Mr. ☐Mrs. ☐Ms. ☐Miss	First Name	Middle Name	Last Name	SS# *(Required)*
Sex: ☐ M ☐ F	Age	Date of Birth	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	
Address:			Home Phone: Cell Phone:	
City:	State:	Zip:	E-mail Address:	

Preferred language: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race:☐ American Indian ☐ Asian ☐ African-American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Employer:	Occupation:
Work Address:	Work Phone:
Spouse / Parent Name:	
Spouse / Parent Employer:	Occupation:
Work Address:	Work Phone:

Emergency Contact Name: Relationship to Patient Phone

Primary Care Physician: Phone:

Contact Preference: ☐ Patient Only; ☐ Patient and/or Spouse; ☐ Anyone Answering Phone

_____

How did you learn of our practice? ☐ Primary Care Physician ☐ Referral by friend/family (specify) ☐ Internet

☐ Yellow Page ☐ Door / Street Sign ☐ Insurance Directory ☐ Other (specify) _____

Acknowledgement of Receipt of Notices of Privacy Practices

I acknowledge that I was offered a copy of the Notice of Privacy Practices that is available upon request and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Signature: _____ Date: _____