Patient Registration Form

Demographics

Name:	DOB:	Sex:
Address: Street	City/State	Zip
Phone Number: Home	Mobile	Work
Email:		
Marital Status: □ Single □ Significant Other □ Married □ Widowed □ Divorced		
Race: □ American Indian/Alaskan Native □ Asian: _____ □ Black or African American □ Native Hawaiian □ White □ Other: _____ □ Decline		
Ethnicity: □ Mexican, Chicano/a □ Cuban □ Puerto Rican □ Other Hispanic, Latino/a □ Not Hispanic, Latino/a □ Unknown □ Decline		
Veteran Status: □ Never Served □ Currently Serving □ Combat Veteran □ Other Veteran		

Employment

Status: □ Full time □ Part time □ Not employed □ Active Military Duty □ Disabled □ Retired □ Self-employed □ Student - Full time □ Student - Part time	
Employer:	Occupation:

Emergency Contact

Name:	Relationship:	Number: □ mobile □ home □ work

Insurance Holder Information

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other: _____ If you are not the primary subscriber, please fill out the following information for the subscriber.		
Name:	DOB:	
Address: Street	City/State	Zip □ same as me
Employment Status: □ Full time □ Part time □ Not employed □ Active Military Duty □ Disabled □ Retired □ Self-employed □ Student - Full time □ Student - Part time		