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## PATIENT REGISTRATION FORM

Please PRINT CLEARLY to make sure all information will be entered correctly – ALL AREAS MUST BE COMPLETED

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name (Last, First, MI) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Gender: M  F  Marital Status: S  M  W  D  Preferred Language: English  Spanish  Refuse to Report

Race: African American  Asian  American Indian  Native Hawaiian  Pacific Islander  White  Other  Refuse to Report

Ethnicity: Non-Hispanic  Hispanic  Refuse to Report

## GUARANTOR INFORMATION

(Person financially responsible for bills when patient is under 18 years of age)

If information is same as patient, please check here:

Guarantor Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Contact Number: (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Social Security # \_\_\_\_\_ Subscriber DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's relationship to insured: Self  Spouse  Dependent Child  Other  \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Social Security # \_\_\_\_\_ Subscriber DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's relationship to insured: Self  Spouse  Dependent Child  Other  \_\_\_\_\_

Information can be released to the following: (family member, friend, etc.)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient / Responsible Party Signature \_\_\_\_\_