WEST BEND FAMILY MEDICINE

Keeping you and your family healthy.

Patient Registration Information

<table>
<tr><td colspan="2">DOB (mm/dd/yyy):</td><td colspan="2">Today's Date:</td></tr>
<tr><td>Last Name:</td><td colspan="2">First Name:</td><td>MI</td></tr>
<tr><td colspan="4">Physical Address:</td></tr>
<tr><td colspan="4">Mailing Address:</td></tr>
<tr><td colspan="2">Preferred Name:</td><td colspan="2">Phone Number:</td></tr>
<tr><td colspan="2">Email Address:</td><td colspan="2">Social Security Number:</td></tr>
<tr><td>Preferred Pronoun
☐ he/him
☐ she/her
☐ they/them
☐ ze/zim
☐ choose not to disclose</td><td colspan="2">What gender do you identify as? ☐ Male
☐ Female
☐ Trans –Male to Female
☐ Trans – Female to Male
☐ Other</td><td>Legal Sex:
☐Male ☐Female
☐Non-binary

Sex assigned at birth:
☐Male ☐Female
☐Unlisted/Unknown</td></tr>
<tr><td colspan="2">Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Significant Other ☐ Legally Separated</td><td colspan="2">Sexuality: ☐ Heterosexual / Straight ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Other: _____</td></tr>
<tr><td>Race:
☐ White ☐ Asian
☐ African American
☐ Native Hawaiian
☐ Other:</td><td>Ethnicity:
☐ Hispanic
☐ Non-Hispanic</td><td colspan="2">Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed ☐ Other: _____
If employed, are you currently employed in healthcare? ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Veteran Status: Have you ever served in the US Military?
☐ Yes ☐ No ☐ choose not to disclose</td><td colspan="2">Do you live in public housing or congregate care?
☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Preferred Language:</td><td colspan="2">Written Language:</td></tr>
<tr><td colspan="4">Emergency Contact #1</td></tr>
<tr><td>Full Name</td><td>Relationship</td><td colspan="2">Phone Number</td></tr>
<tr><td colspan="4">Emergency Contact #2</td></tr>
<tr><td>Full Name</td><td>Relationship</td><td colspan="2">Phone Number</td></tr>
</table>

Financial Guarantor (who holds the insurance and is responsible for payment)		
Full Name	DOB	SSN