PATIENT REGISTRATION (Please Print Clearly) ***NEW Patient_____ UPDATE Demographics_____***

Today's Date_____
Patient Name_____
Address_____
City_____State_____Zip_____
Home Phone_____ Cell Phone _____Work Phone_____
Birth date_____ Age_____ Sex: M F Trans Marital Status: M D P S W
Patient Social Security #_____ Employer_____
Spouse/Partner/ or Parent-Guardian Name_____
Spouse/Partner/Parent-Guardian Phone_____

Email (if no email state NONE): _____

Please circle *one from each list*

Race:	***Ethnicity***	***Primary Language Spoken***
American Indian or Alaska Native	Hispanic or Latino	English
Asian	Not Hispanic or Latino	Spanish
Black or African American	Rather not report	French
Hispanic		Mandarin
White		Other
Other Race		
Rather not report		

Emergency Contact_____ Relation to you_____
Emergency Contact Phone_____
Ok to talk to emergency contact regarding personal medical information as covered by HIPAA _____Yes _____No

Preferred Pharmacy_____ City_____

Financially Responsible Party Self (if 18 yrs. or over) **OR** Other
Name (if other than self) _____
Address: _____
City: _____State:_____Zip:_____
Phone: _____
Birth date of Responsible Party_____ Social Security #_____

Is it okay to leave a message on **your** listed phone(s) or email regarding your appointment reminder and/or other medical care? _____Yes _____No
Is it okay to leave a message the listed phone for your **spouse/domestic partner** regarding your appointment reminder and/or other medical care? _____Yes No_____

How or by whom were you referred to West Bend Family Medicine?_____