PATIENT REGISTRATION (Please Print Clearly) ***NEW Patient_____UPDATE Demographics_____***

Today's Date_____

Patient Name_____ Preferred Name/Maiden Name:_____

Birth date_____ Age_____ Sex: M F Other: Marital Status: S M P$_{artnered}$ W D

Address_____

City_____State_____Zip_____

Primary Phone:_____ Type:_____ O Text O Voicemail O No Message Please

Secondary Phone_____ Type:_____ O Text O Voicemail O No Message Please

Email (for Web Portal Access): _____

Is it okay to leave a voice message or text message on **your** listed phone(s) or email regarding your appointment reminder and/or other medical care? O Yes O No

Patient Social Security #_____Employer_____

O Spouse/Partner ***or*** O Parent/Guardian Name_____

O is Primary Emergency Contact

O Spouse/Partner ***or*** O Parent/Guardian Phone_____O is Financially Responsible Party

Ok to talk to emergency contact regarding personal medical information as covered by HIPAA? O Yes O No

Secondary Emergency Contact _____Relationship:_____

Secondary Contact Phone_____O is Financially Responsible Party

Ok to talk to emergency contact regarding personal medical information as covered by HIPAA? O Yes O No

Preferred Pharmacy_____City_____

PRIMARY *Medical Insurance Name:*_____

*Primary Subscriber: Self Spouse/Partner Parent Other Primary Subscriber Date of Birth*_____

*Name (if other than self)*_____

SECONDARY *Medical Insurance Name:* _____

*Primary Subscriber Self Spouse/Partner Parent Other Primary Subscriber Date of Birth*_____

*Name (if other than self)*_____

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	Other:	Mandarin
White		Other:
Other Race :		
Rather not Report		

Signature:_____