PATIENT REGISTRATION

Patient Name_____Birthdate_____/_____/_____ Sex □ M □ F

Marital Status □ Single □ Married □ Widowed □ Divorced □ Minor

SS#_____Home Phone ( )_____

Street Address_____ Alternate Phone ( ) _____

P.O. Box_____City_____State_____Zip_____

Employer_____Work Phone ( )_____

Spouse Name_____Birthdate_____/_____/_____SS#_____

Employer_____Work Phone_____

Primary Care Provider Name:_____

Preferred Method of Contact: □ Home Phone □ Alternate Phone □ Work Phone □ Emergency Phone

Emergency Contact Name:_____Phone:_____

Employment Status: □Full-time □Part-time □Retired □Disabled □Self-Employed □Unemployed □Student

Insurance Information ***WE WILL MAKE COPIES OF ALL INSURANCE CARDS****

Primary Insurance_____
Name of Subscriber_____ Birthdate____/____/____Relationship_____

Secondary Insurance_____
Name of Subscriber_____Birthdate___/____/____ Relationship_____

Tertiary Insurance_____
Name of Subscriber_____Birthdate____/____/___ Relationship_____

Is this a worker's compensation claim? □ No □ Yes – if yes, date of injury_____

Is this an auto claim? □ No □ Yes – if yes, date of accident_____
Auto Insurance Carrier_____

As a Federally Qualified Health Center, we are required to gather certain demographic information about our patient population. Please check all boxes that apply to you. Thank you.

Race
□ American Indian
€ Asian
€ Black / African American
€ Hispanic / Latino
€ Native Hawaiian
€ Other Pacific Islander
€ White

Homeless Status
€ Not Homeless
€ Doubling Up
€ Shelter
€ Street

Migrant Worker
€Migrant
€Not a Farm Worker
€Seasonal

Veteran
□ Yes
□ No

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