Specialists℠

Patient Registration Form

Patient Name: _____ **Preferred Name:** _____
Last First M.

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

SSN#: _____ DOB: _____ Age: _____ Marital Status: _____

Sex: _____ Gender Identity: _____ How did you hear about us?_____

Mobile Phone: (_____)_____-_____ Home Phone: (_____)_____-_____

Work Phone: (_____)_____-_____ Preferred Contact: ☐ Home Phone ☐ Mobile Phone

E-Mail: _____ ☐ Work Phone

Emergency Contact Name: _____
Last First M.

Relationship: _____ Emergency Contact #: (_____)_____-_____

☐ Part Time Student ☐ Full Time Student ☐ Employed Full Time ☐ Employed Part Time ☐ Retired

Occupation: _____ Employer: _____

School: _____ Military Branch: _____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Hispanic

☐ Other: _____ Ethnicity: _____

Preferred Language: _____ Translator Needed: ☐ Yes ☐ No

Primary Care Physician:

Name: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

Referring Physician:

Name: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

Primary Insurance

Insurance Company: _____ Plan Name: _____

Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB:_____
Last **First** **M.**

Relationship to Policy Holder: _____ Policy Holder #: (_____)_____-_____

Policy Holder Address: _____

Secondary Insurance

Insurance Company: _____ Plan Name: _____

Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB:_____
Last **First** **M.**

Relationship to Policy Holder: _____ Policy Holder #: (_____)_____-_____

Policy Holder Address: _____

Patient Signature: _____ **Date:** _____

Over to Communication Consent