REGISTRATION/PATIENT INFORMATION

PATIENT INFORMATION

Last Name: **First:** **Middle:**

Social Security Number: ____/____/_____

Date of Birth: Gender : **Male** or **Female**

Address: **City:** **State:** **Zip:**

Primary Phone: Secondary Phone 2:

E-mail:

Marital Status: **Married** **Widow** **Divorced** **Single**

Employment Status: **Full Time** **Part Time** **Self Employed** **Unemployed**
Active Military **Retired (Date) _____** **Disabled (Date) _____**

Employer:

Primary Care Physician: **Referring Physician:**

IN CASE OF EMERGENCY/GUARDIAN of MINOR

Name: Relationship: Phone number:

Ethnicity

Would you declare your preferred language? English _____

Would you declare your race and ethnicity? Yes No Declined/Refused Unavailable

If yes, do you consider yourself Hispanic/Latino? Yes No

Which category best describes your race?

*American Indian/ Alaska Native	* Black/African American	*Asian
*Multi-racial	*White	*Other
*Unknown	*Declined/Refused	*Unavailable

Additional info

Do you have Advance Directives/Legal Guardian/HealthCare/Proxy? YES NO

Communication needs: **Interpreter** **TTD** **Visual** **OTHER**

Ver 8/2/2016