

Patient Registration

Dr. Miss
Mr. Ms.
Mrs.

Circle One	First Name	Middle	Last name	Date of Birth	Social Security #
Address		City	State	Zip	
Home Phone	Cell Phone	Work Phone		Email	
Employer Name/Address				Spouse	

Race <input type="checkbox"/> American Indian or Alaskan American <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> No Answer Given	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> No Answer Given	Preferred Contact Method <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text	How did you hear about us? <input type="checkbox"/> Already a Patient <input type="checkbox"/> Phone Book <input type="checkbox"/> Dr. Referral <input type="checkbox"/> Insurance Listing <input type="checkbox"/> Website <input type="checkbox"/> Facebook <input type="checkbox"/> Friend _____ <input type="checkbox"/> Family _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Other (please specify) _____		

Insurance Information			
Vision Insurance Name	Policy Number	Group Number	
Insured's Name	Insured's Date of Birth	Insured's Social Security #	Relationship to Patient

Responsible Party (if different than patient)	Additional Information
Name _____	Primary Physician _____
Date of Birth _____	City _____
Soc Sec # _____	May we communicate/correspond with your primary physician regarding your care? Circle one Yes No Please initial _____
Address _____	Pharmacy/City _____
City/State/Zip _____	I authorize doctors and staff to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following individuals:
Home Phone _____	
Cell _____	
Employer Name _____	Name/Relationship _____
Work Phone _____	Name/Relationship _____
	Name/Relationship _____