Healthcare Provider

Patient Registration

Patient Information			
Last Name:	**First Name:**	**Date of Birth:**	
Street Address:	**City:**	**State:**	**Zip:**
Mobile Phone:	**Work Phone:**	**Email:**	
Preferred Method of Contact for Notifications: ☐ Email ☐ Phone Call (Mobile) ☐ Text Message ☐ Phone Call (Work)			
Sex: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated		

Responsible Party, Parent, or Guardian			
Last Name:	**First Name:**	**Date of Birth:**	
Street Address:	**City:**	**State:**	**Zip:**
Mobile Phone:	**Work Phone:**	**Relationship to Patient:**	

Additional Information		
Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Other:		
Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Arabic ☐ American Sign Language ☐ Other:		
Emergency Contact Last Name:	**Emergency Contact First Name:**	**Emergency Contact Phone:**
Relationship to Patient:	**Family Physician or Pediatrician:**	**Preferred Pharmacy Name & Location:**

Primary Health Insurance	Secondary Health Insurance
Insurance Company Name:	**Insurance Company Name:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder Date of Birth:	**Policy Holder Date of Birth:**
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

My signature below certifies that I have read and agree to Healthcare Provider's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize Healthcare Provider to release any medical information to my insurance carrier or third party payer to facilitate processing my claims. I choose to receive communications from Healthcare Provider by text or email at the number or address stated above, including communications about appointments, feedback, treatment, and payment.

Signature of Patient, Responsible Party, Parent, or Guardian: _____

Date signed: