



Patient Registration Form

Patient Label

Patient Information

Last Name		First Name		MI	Date of Birth
Address		Apt./Unit	City		State Zip Code
SSN		Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address		
Please select primary phone <input type="checkbox"/> Home Phone (____)____-____ <input type="checkbox"/> Cell Phone (____)____-____ <input type="checkbox"/> Work Phone (____)____-____					
Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (Select all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Korean <input type="checkbox"/> Samoan <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chose Not to Disclose Race					
Ethnicity <input type="checkbox"/> Mexican, Mexican American <input type="checkbox"/> Cuban <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Hispanic/Latino/Spanish <input type="checkbox"/> Hispanic/Latino/Spanish Origin <input type="checkbox"/> Decline to Specify					
Sexual Orientation <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Chose Not to Disclose <input type="checkbox"/> Other: _____			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Gender Identity (How do you identify yourself?) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Man/Transgender Male/Transmasculine <input type="checkbox"/> Transgender Woman/Transgender Female/Transfeminine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Chose Not to Disclose					
Are you an Agricultural Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please select a class of work</i> <input type="checkbox"/> Migratory <input type="checkbox"/> Seasonal			Preferred Pronouns <input type="checkbox"/> He, Him, His <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Other: ____ <input type="checkbox"/> Choose not to disclose		
Education Completed? <input type="checkbox"/> High School Diploma <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's <input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above			Are you currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please select a living arrangement</i> <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Transitional <input type="checkbox"/> Shelter <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Other		

Parent/Guardian Information (If applicable)

Last Name	First Name	Date of Birth	Primary Phone (____)____-____	Relation to Patient
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Guarantor Information (If not patient)

Last Name	First Name	Date of Birth	Primary Phone (____)____-____	Relation to Patient
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Medical Insurance Information

Primary Insurance Name	Subscriber Name	Subscriber ID	Group ID#
Secondary Insurance Name	Subscriber Name	Subscriber ID	Group ID#

Dental Insurance Information (If applicable)

Primary Insurance Name	Subscriber Name	Subscriber ID	Group ID#
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Emergency Contact

Last Name	First Name	Relation to Patient	Phone Number (____)____-____
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Signature	Relation to Patient (if not patient)	Date
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By signing you are verifying all the information above is true and correct