Registration Packet

Patient Name: _____
(Last) (First) (Middle Initial) (Previous Name)

Date of Birth: _____ SS#_____

Sex/Gender
Sex (Legal): _____ (Female, Male, Nonbinary, Unknown, X)
Gender Identity: _____Sex assigned at birth: _____Sexual orientation: _____

Billing Address (if this is different from the Driver's License, please complete)
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ ☐ Able to receive text messages
Alternate #: _____ ☐ Able to receive text messages
Email Address: _____
Preferred Method of Communication: _____ (Phone/Email)

PCP: _____ Contact #: _____

Preferred Pharmacy: _____
Pharmacy Phone #: _____ Address: _____

Preferred Pharmacy: _____
Pharmacy Phone #: _____ Address: _____

Written Language: _____Preferred Language: _____
☐ Language Interpreter needed
☐ American Sign Language Interpreter needed

Marital Status:
☐ Divorced
☐ Legally Separated
☐ Married
☐ Partner
☐ Significant Other
☐ Single
☐ Widowed
☐ Other

Race:
☐ Am. Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Hawaiian/Pacific Islander
☐ White/Caucasian
☐ Other
☐ Unknown

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Other
☐ Unknown

Employment Status:
☐ Disabled
☐ Full Time
☐ Homemaker
☐ Not Employed
☐ Active Military
☐ Part Time
☐ Retired
☐ Self Employed
☐ Student-Full time
☐ Student-Part time
☐ Volunteer

Employer Name: _____ Occupation: _____
Phone #_____ Dept./Ext. #: _____
Employer Address: _____

Patient Contact (Emergency Contact) Name: _____
Relationship: _____
Primary #: _____ Alternate #: _____

I certify that the demographic and insurance information on this form is current and accurate to the best of my knowledge.

If a patient is a minor or an adult without capacity to consent to their own care, please have the Health Care Decision Maker sign below.

X_____
(Patient Signature)

_____
(Print Name)

_____ _____
(Date) (Time)

X_____
(Authorized Health Care Decision Maker/Authorized Patient Representative Signature)

_____
(Print Name) (Relationship to Patient)

_____ _____
(Date) (Time)

Important Note for Health Care Decision Maker:

- All documents (Healthcare or Medical Power of Attorney, Health Care Agent, Legal Guardianship, Custody documents (both joint and sole custody)) must be presented at time of New Patient Appointment. Updates must be provided to practice.

Please complete ONLY FOR PEDIATRIC PATIENTS
If you are not a pediatric patient STOP here

Siblings (list all)

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Children live with: ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Other** _____
☐ **Custodial Guardian** _____ **(Paperwork required)**

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If address is different from patient address, please provide below.

Father's Name: _____ Mother's Name: _____
Address: _____ Address: _____
City: _____ City: _____
State: _____ Zip Code: _____ State: _____ Zip Code: _____
Primary Phone: _____ Primary Phone: _____
Alternate Phone: _____ Alternate Phone: _____
DOB: _____ DOB: _____