## **New Patient Registration**

## **Patient Information**

Full Legal Name:

Preferred Name:

Social Security # Date of Birth

Sex Assigned at Birth: FemaleMale Choose Not to Disclose

Gender Identity: FemaleMale  Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Choose Not to Disclose

Pronoun(s): she/her/hershe/him/his  Other **(**Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Choose Not to Disclose

Street Address

City State Zip

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Same as Street

City State Zip

Phone: Home Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address

Communication Preference: MyChart Email Mail Phone No Preference Do Not Contact

Text Messages OK? YesNo (please provide a mobile number above to receive text messages)

Ethnicity: HispanicNon-Hispanic Unknown

Race (check all that apply): Alaskan NativeAmerican Indian Asian Black

Pacific Islander White Unknown Choose Not to disclose

Primary Language (if not English) Do you need an interpreter? YesNo

### Are you a Veteran of the US Armed Services? Yes No

### Emergency Contact Information

Emergency Contact Relationship

Emergency Phone (Home) (Work)

Guarantor Account Information (Responsible Party for Payment)

Name Social Security # Date of Birth

Relationship to Patient Self

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Same as Patient

City State Zip

Phone: Home Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work

Email Address

**Insurance Coverage Information** (Please provide your insurance card to the front desk)

Insurance Provider Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Self

Member # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this application, I affirm under penalty that I have given true and complete information.**

Patient Signature Date

Guarantor Signature Relationship to Patient