## **New Patient Registration**

## **Patient Information**

Full Legal Name:

Preferred Name:

Social Security # Date of Birth

Sex Assigned at Birth: **[ ]** Female **[ ]** Male **[ ]** Choose Not to Disclose

Gender Identity: **[ ]** Female **[ ]** Male **[ ]**  Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[ ]** Choose Not to Disclose

Pronoun(s): **[ ]** she/her/hers **[ ]** he/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? **[ ]** Yes **[ ]** No (please provide a mobile number above to receive text messages)

Ethnicity: **[ ]** Hispanic **[ ]** Non-Hispanic **[ ]** Unknown

Race (check all that apply): **[ ]** Alaskan Native **[ ]** American Indian **[ ]** Asian **[ ]** Black

[ ] Pacific Islander **[ ]** White **[ ]** Unknown **[ ]** Choose Not to disclose

Primary Language (if not English) Do you need an interpreter? **[ ]** Yes **[ ]** No

### 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