PATIENT REGISTRATION

PATIENT NAME:_____ **SEX:** □ **MALE** □ **FEMALE** **DOB:**_____

FIRST VISIT:_____ **UPDATED INFO ONLY:** □_____

HOME ADDRESS:

CITY/STATE/ ZIP CODE:_____

_____

_____

HOME PHONE NUMBER: (_____) _____ **MOM CELL&WORK #:** _____

DAD CELL& WORK #: _____

EMAIL ADDRESS: _____

(REQUIRED FOR PATIENT PORTAL)

MOTHERS NAME:_____ **BIRTHDATE:**_____

FATHERS NAME:_____ **BIRTHDATE:**_____

EMERGENCY CONTACT NAME AND #: _____

(CLOSEST RELATIVE NOT A PARENT)

PATIENT SIBLINGS: _____

_____

_____

ALLERGY TO MEDICATIONS: □ **YES** □ **NO** **LIST MEDICATION IF YES:** _____

HEALTH INSURANCE COMPANY: _____

_____

SUBSCRIBER NAME/CARDHOLDER NAME:_____

DATE OF BIRTH OF SUBSCRIBER:_____

PATIENT ID #:_____

GROUP #:_____

INSURANCE TELEPHONE #:_____

PATIENT DEMOGRAPHIC QUESTIONNAIRE:

We are asking for your race and ethnicity because some people have higher risks of developing certain diseases. It is important that know your preferred language so that you can communicate with your health care team. We will keep this information confidential.

Please fill in the information below:

1. Race:

- □ **WHITE/CAUCASIAN**
- □ **BLACK/AFRICAN AMERICAN**
- □ **AMERICAN INDIAN OR ALASKA NATIVE**
- □ **ASIAN**
- □ **NATIVE HAWAIIAN**
- □ **OTHER PACIFIC ISLANDER**
- □ **MORE THAN ONE RACE**
- □ **PREFER NOT TO ANSWER**

2. Are you of Hispanic Origin? □ **Yes** □ **No**

3. Please indicate spoken language:

_____

Signature: _____

Date:_____