PATIENT REGISTRATION

Please review, make necessary changes and supply any missing information.

Patient Name		**DOB:** **AGE:**	**Sex:**
Address			**SS#**

COMMUNICATION			
How best to contact you?	Home Phone Cell Phone Work Phone Email US Mail		
Home Phone #		**Work Phone #**	
Cell Phone #		**Email**	
Emergency Contact			**Phone:**

INFORMATION			
Plan Type		**Special Needs**	
Marital Status		**Employer**	

Of the following categories listed below, how do you describe yourself? Please circle one answer below.

White *Black or African American* *Asian* *American Indian or Alaskan Native*
Native Hawaiian or Other Pacific Islander *Other Race* *Decline to Answer*

Of the following categories listed below, how do you describe yourself? Please circle one answer below.

Hispanic or Latino *Non Hispanic or Latino* *Decline to Answer*

Primary Language		**PCP:**	**OD:**

FINANCIAL RESPONSIBILITY					
Responsible				**Salutation**	
Relationship				**SS #**	
Address					
Home Phone #		**Work Phone #**		**Extension**	

PRIMARY INSURANCE			
Carrier		**Co Pay**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Carrier		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

VISION INSURANCE			
Plan		**ID #**	
Insured		**Date of Birth**	