

***PATIENT REGISTRATION INFORMATION***

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| **Patient Information** | **Patient Demographic Information** | | | | | | | | |
| Last Name: | | | **First Name:** |  |  | **M.I.:** | Previous Name (if applicable) | |
| Mailing Address: |  |  |  |  | **Apt #** |  |  |  |
| **City/State/Zip:** | | | | | | | | |
| Home Phone: | | **Cell Phone:** | | | | **Work Phone:** | | |
| **Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:** | | | | |  | **If Voice, Please Select Preferred Number:** | | |
| **(Please Select Only One Option)  Voice  Text** | | | |  |  | * **Home  Cell  Work** | | |
| **Family Physician** | | | | **Date of Birth:** | | | | Sex:   * Male  Female |
| **Marital Status:**   * **Married** * **Single** * **Divorced** * **Separated** * **Widowed** * **Other** | | | | **Social Security #:** | | | | |
| **Employer Name:** | | | | **Emergency Contact Name:** | | | | |
| **Emergency Contact Phone #** | | | | | | **Relationship to Patient:** | | |
| **Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)** | | | | | | | | |
| **Email Address:** | | | | | **Can we leave a message regarding your medical care & test results?**  ** Yes  No** | | | |
| **Race**  **(please select)** |  |  |  |  | **Ethnicity**  **(please select one):** | |  |  |
| * White/Caucasian * Hispanic * Native Hawaiian or Pacific Islander * Black or African American | * American Indian or Alaska Native * Asian * Decline * Other | |  |  | * **Hispanic or Latino** * **Not Hispanic or Latino** * **Decline** | |  |  |
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