

***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
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| **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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