Patient Registration Form

We do not discriminate against any person on the basis of race, color, national origin, sex, age, religion, or disability, in our programs and services

Patient Information

Please provide your photo ID to the Receptionist

Last Name: First Name:

Date of Birth: SSN: Sex: ☐ Male ☐ Female

Primary Language: Transgendered: ☐ Yes ☐ No

Mailing Address: _____

Physical Address: _____

Home Phone: Work Phone: ext:

Cell Phone: E-mail Address:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner ☐ Unknown

Race: ☐ White (to include Hispanic or Latino) ☐ Black or African American ☐ American Indian / Alaska
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race:

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Insurance or Payment Source

Please provide your Insurance Card(s) to the Receptionist

☐ Medicaid ☐ CHIP ☐ Medicare ☐ Private Pay (self-pay) ☐ Other _____

☐ Commercial Insurance
- Name of Insurance:

☐ Medicare with Supplement Insurance
- Name of Insurance:

Employment Status

☐ Full-time ☐ Self Employed ☐ Retired ☐ Active Duty Military

☐ Part-time ☐ Not Employed ☐ Unknown

Responsible Party

☐ Self (*patient listed above*)

☐ Guarantor; please complete the following details:

Last Name: First Name:

Date of Birth: Relationship to patient:

Address: _____

Best Contact Telephone Number: ☐ Home ☐ Cell ☐ Work

Emergency Contact

Last Name: First Name:

Home Phone: Work Phone: ext:

Cell Phone: Relationship to patient:

Preferred Pharmacy:

Pharmacy Name: _____

Address:

☐ I acknowledge my responsibility to pay for services rendered and understand that I will be responsible for any fees that are not paid by my Insurance or covered by HealthPoint programs.

Please initial