PATIENT REGISTRATION DATA

Patient's Legal Name:	Marital Status: M S W D Sep	Sex: Male Female	Social Security Number ____ - ____ - ____

Patient's Date of Birth: ____/____ /____	Street Address including city, State, Zip Code:	Home phone: Cell phone: Work phone:

Mailing Address including City, State and Zip Code: (If using PO Box please list your physical address above)

(For Patient) Employer's name / address:

Email Address:

Race: (please check one)	Preferred Language:	Ethnicity:
☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander		☐ Hispanic or Latino ☐ Not Hispanic or Latino

Nearest Contact Person (s)	Relationship to Patient	Phone Numbers: ____ - ____ - ____ ____ - ____ - ____
If Patient is a minor, who may authorize medical treatment?	Relationship to Patient	Phone Numbers: ____ - ____ - ____ ____ - ____ - ____

Insurance Company	Primary:	Secondary:
I.D. Number		
Subscriber Name		
Subscriber DOB		
Subscriber SSN		
Subscriber Address		
Employer/Group #		
Co Payment Amt		

If you authorized release of your medical information to anyone other than your insurance carrier, please ask to fill out a HIPAA release of information for each individual so that we may keep this on file for you.

May we leave a message:
At your home? ☐ No ☐ Yes, *Brief* or *Extended*
On your cell phone? ☐ No ☐ Yes, *Brief* or *Extended*
At your work? ☐ No ☐ Yes, *Brief* or *Extended*

Which pharmacy would you like to use, if necessary?	I have received a copy of Notice of Privacy Practices (please initial one) NO _____ YES _____
Who is the patient's Primary Care Physician?	Who referred the patient to this specialty?

I authorize Central Peninsula Physician Services to release to the named insurance company(s) any information that is necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

_____ _____ _____ _____
Responsible Party Signature | Relationship to Patient | Date | Time

_____ _____ _____
Address of Responsible Party | Phone | Witness Signature

_____ _____ _____ _____ _____
SS# | DL# | DOB# | Date | Time

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There will be a $25 fee for all checks returned for Non-Sufficient Funds