

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: ____/____/____	Mailing Address including City, State and Zip Code: _____		Home phone: Cell phone: Work phone:	
Street Address including City, State, Zip Code: _____				
(For Patient or Parent) Employer's Name: _____ Occupation: _____				
Employment Status: (Circle One) Full Time Part Time Not Employed Student Disabled Retired				
Email Address: _____				
Race: (please check one) <input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		Preferred Language: _____ Needs Interpreter? Y / N		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Emergency 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.				
How would you like to be contacted for appointment reminders? : (Circle One) Text Phone Call Email				
Religion: _____		Hearing Impaired? Y / N Visually Impaired? Y / N		
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 _____

