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)	Preferred Language:	Ethnicity:
☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander	______________ Needs Interpreter? Y / N	☐ Hispanic or Latino ☐ 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

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