Registration and Update Form (Confidential)

- Please complete all ➢ **Required sections** of this form then
- Provide an **Insurance Card** and **Photo ID** for copying
- If you have any questions or concerns, please ask for assistance. We will be happy to help.

➢ **Patient Information**

Last Name:________________________ First Name:______________________ Middle Name:____________________

Social Security #:___________________________ Gender:___________ Date of Birth:___________________________

Mailing Address:____ City:____________________________

State:_________ Zip:________________

Phone (Mark the best) ❑ Home:________________________________ ❑ Work:____________________________

❑ Mobile:_______________________________ ❑ Message:_________________________

Aliases / Nick Name:________________________________ E-mail:____

➢ **General** ❑ Needs Interpreter If yes; Language:______________________________ Religion:___________________

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated

Ethnicity: ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American
❑ Native Hawaiian/Pacific Islander ❑ White/Caucasian ❑ Other:____________________________________

Employer:____ Employment Status: ❑ Part Time ❑ Full Time
❑ Never Employed ❑ Not Employed ❑ Active Military Duty ❑ Disabled ❑ Retired ❑ Self Employed
❑ Student Full Time ❑ Student Part Time

Employer Address:______________________________________ City:_______________ State:_______ Zip:_________

Occupation:____ Phone__________________________________

➢ **Primary Care Doctor** **(Doctor, Nurse Practitioner, Physicians Assistant, etc.)**

Dr. Name:____ Phone:_______________________________

➢ **Patient Emergency Contacts At least 1 immediate family member**

Name:___________________________________ Relationship:_____________________ Phone:___________________

Name:___________________________________ Relationship:_____________________ Phone:___________________

➢ **Financially Responsible Party (Guarantor)** **(Complete if Guarantor is the parent or anyone other than the patient)**

Guarantor Name:__________________________________ Relationship to Patient:___________________________

Address:____ City:_____________________ State:_______ Zip:_________

Social Security #:__________________________________ Gender:____________ Date of Birth:___________________

Home Phone:____ Work Phone:_____________________________________

Employer:____ Employment Status: ❑ Part Time ❑ Full Time
❑ Never Employed ❑ Not Employed ❑ Active Military Duty ❑ Disabled ❑ Retired ❑ Self Employed
❑ Student Full Time ❑ Student Part Time

Employer Address:______________________________________ City:_______________ State:_______ Zip:_________

Occupation:____ Phone:____

➢ **Coverage Information**

Primary Insurance:___________________________ Subscriber ID:_____________________ Group #:___________________

Subscriber Name:__________________________ Date of Birth____________________ Relationship:_______________

Address:____ City: ____________________ State:_______ Zip:_________

Secondary Insurance:_________________________ Subscriber ID:_____________________ Group #:___________________

Subscriber Name:__________________________ Date of Birth____________________ Relationship_________________

Address:____ City: ____________________ State________ Zip:_________

➢ **Advanced Directives** Do you have any Advanced Directives? ❑ Yes ❑ No