

# Patient Registration

Date of Visit: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Patient Social Security #: \_\_\_\_\_ Language \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Gender: F M Marital Status: M D S W

Race:  American Indian  Asian  Black/African American  Native Hawaiian  White

Hispanic/Latino  Refuse to Answer  Other: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

## Patient Past Medical History

Major Medical Problems: \_\_\_\_\_

Major Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_ Pharmacy /Location: \_\_\_\_\_

## Social History

Smoker: Y N Alcohol Consumption: Y N Recreational Drugs: Y N

## Insurance Information

Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth : \_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Prime Immediate  
and Primary Care