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Patient Registration

Please verify the following information, make necessary changes and supply any missing information.

Patient Information

Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Nickname	Date of Birth	Today's Date		
				Social Security #	Birth State	Sex	Age

Address	Address Type (Home, Billing Address, Office/Business)	Country

Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)

Preferred Local Pharmacy	Preferred Mail Order Pharmacy

Primary Language	Special Needs	Marital Status	Maiden Name	Mother's Maiden Name	Plan Type

Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)	Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)

Race	Race 2	Ethnicity	Ethnicity 2

Employer	Occupation

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Patient's Relationship to the Responsible Party (Self, Spouse, Child)		
		Home Phone	Cell Phone	Work Phone / Ext

Address (Street, City, State, ZIP)	Email Address	Social Security #	Gender

Last Sent	Last Payment Received	Insurance Balance	Total Balance

Primary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Insurance Company Address	PAY %
	100

Group Name	Group Number	Copay

Secondary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Insurance Company Address	PAY %

Group Name	Group Number

Contacts

Name/ Relationship/ Address	Title/ Specialty	Emergency Contact	Release Medical Info	Phone Numbers/ Fax

Legal, Work or Auto Injury Contacts

Name/ Numbers/ Fax	Role/ Title	Address	Release Medical Info	Claim Number/ Pertinent Info

Referrals

Firm/Organization/Name	Phone	Address	Reason	Authorization Number