



## PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Preferred Name (Nickname): \_\_\_\_\_ Gender: M  F

Address: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
OK to Text?  Yes  No

Email: \_\_\_\_\_

PCP (if other than HFCC): \_\_\_\_\_ Office Location: \_\_\_\_\_

**Marital Status:**  Married  Single  Divorced  Separated  Widowed  Partner

**Language:**  English  Spanish  Chinese  Arabic  Other: \_\_\_\_\_

**Ethnicity:**  Hispanic or Latino/Spanish  Not Hispanic or Latino  Patient refused

**Race:**  White  American Indian or Alaska Native  Asian  Black or African American  Middle Eastern or  
North African  Native Hawaiian or Other Pacific Islander  Other \_\_\_\_\_  Patient refused

Emergency Contact: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Name Relationship Phone Number

How did you hear about us? \_\_\_\_\_

Check box if you wish to *opt out* of our mailing list

### **Insurance Information**

**\*\*IF card(s) not taken at front desk\*\***

Insurance Plan: \_\_\_\_\_ ID #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_ ID #: \_\_\_\_\_

Financial Responsible Party (if other than patient) Name & DOB: \_\_\_\_\_

\_\_\_\_\_

Signature of patient or legal guardian/representative

\_\_\_\_\_

Date