Patient Registration Form

Patient information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other		Preferred Language

Race (check all that apply) ❑ American Indian or Alaskan Native   ❑ Asian
❑ Black or African American   ❑ Native Hawaiian or other Pacific Islander
❑ White   ❑ Patient Declined

Ethnicity (check all that apply)
❑ Hispanic or Latino   ❑ Multiple
❑ Not Hispanic or Latino   ❑ Patient Declined

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Email Address	Primary Physician

Responsible Party/Parent/Guardian   (circle one)   Check if same as [   ] Patient

Last Name	First Name	Gender (circle) M / F	Date of Birth	What is Patient's relationship to responsible party?

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City/State	Zip code

Insurance Information   Check if [   ] Self pay

Primary insurance: Check if same as: [ ] Responsible Party	**Secondary insurance:** Check if same as: [ ] Responsible Party
Insurance Name Begin date	Insurance Name Begin date
Subscriber/Member Name Date of Birth	Subscriber/Member Name Date of Birth
What is Patient's Relationship to Subscriber? Gender (circle) M / F	What is Patient's Relationship to Subscriber? Gender (circle) M / F
Insurance Mailing Address City/State Zip code	Insurance Mailing Address City/State Zip code
Subscriber/Member # Group #	Subscriber/Member # Group #

Patient Portal

To receive an invitation to register for the patient portal please ensure you have provided an e-mail address above.

Benefits of the patient portal include: 24/7 access online via a computer or smart phone app for yourself or a designated caregiver to view results and visit summaries, request prescription refills, update your demographics, and send secure messages directly to your provider's staff without having to pick up the phone.

To opt out of the patient portal please check one of the options below:
_____ I am not interested in signing up for the portal at this time   _____ I do not have an e-mail address

_____   _____
Patient/Legal Guardian Signature   Date   Patient/Legal Guardian Print