# Patient Registration


Please complete before your next appointment.

Patient Name *

First Name * | Middle Name | Last Name *

Prior Last Name | Preferred Name

Patient Address *

Address Line 1 *

Address Line 2

City * | State / Province / Region *

Postal / Zip Code *

Seasonal Address

Street Address

Address Line 2

City | State / Province / Region

Postal / Zip Code | Country

If you are a seasonal resident, please complete this section.

Dates you are a seasonal resident:

Patient Gender *

Patient Birth Date *

If patient is a minor, please complete the guardian section

Phone *

Social Security Number

Email

Place of employment or School you are attending:

Emergency Contact *

First Name | Last Name

Phone * | Relationship

Please also add to your HIPAA form

# Responsible Party Information


If Patient is a minor, please complete the following section

Parent/Guardian, Responsible Party:

Parent/Guardian, Responsible Party Date of Birth

Date

Social Security Number

Address

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

Phone Number

# Demographic Information

Patient Race *

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Prefer not to answer
- White

Patient Preferred Language *

Patient Ethnicity *

Primary Care Physician

Referring Physician

Signature *

Type your name in lieu of a signature.

Date: