Patient Registration Demographics

Last Name:_____ First Name:_____MI:_____
D.O.B _____/_____/_____ Sex:_____ Social Security # _____-_____-_____
Primary Language:_____
(*Circle Preferred Answers)*
Ethnicity: *Hispanic/Non-Hispanic/Unknown/Declined to specify*
Race: *White/American Indian or Alaskan/Asian/Black or African American/Hawaiian or Pacific Islander/Declined to specify*
Preferred Primary Doctor: *Hensley/Miller/Golla/Welsh*

Mailing Address:
Street_____ PO Box_____
City _____ County_____
State_____
Zip Code _____

Home Phone: (_____) _____-_____
Patient only Cell Phone (_____) _____-_____ (if applicable, otherwise leave blank)

Who lives at this household? _____

Are parents: *Married/Single/Divorced/Widowed/Separated*

Insurance:
Primary Policy: Policy Holder's Name:_____
Policy Holder's Birth Date: _____ Policy Holder's Sex: _____
Policy Holder SSN:_____ Relation to patient:_____
Insurance Carrier:_____
ID#_____ Group # _____
Policy Effective Date:_____

Secondary Policy: Policy Holder's Name:_____
Policy Holder's Birth Date: _____ Policy Holder's Sex: _____
Policy Holder SSN:_____ Relation to patient:_____
Insurance Carrier:_____
ID#_____ Group # _____
Policy Effective Date:_____

Mother's information (or Contact 1)

Name:_____ Lives with patient? Yes / No
Maiden Name:_____
Social Security Number:_____ Date of Birth: _____/_____/_____
Work Phone (___) ____-_____ Cell Phone: (___) ____-_____
Home email:_____ Home Phone (___)____-_____
Employer: _____ Occupation: _____
Address if different from above:_____
_____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues*: Home phone/ Work phone/ Cell phone*
Appointment Reminders*: Home phone/ Cell phone/ email/text to cell phone*
Recall Notices*: Mailing address/ Home phone/ Work phone/ Cell phone/ e-mail/ Text*
General Practice Notices*: Mailing address/ Home phone/ Cell phone/ e-mail/ Text*
Patient Portal Notifications*: Text to cell phone/ e-mail*

Father's Information (or Contact 2)

Name:_____ Lives with patient? Yes / No
Social Security Number:_____ Date of Birth: _____/_____/_____
Work Phone (___) ____-_____ Cell Phone: (___) ____-_____
Home email:_____ Home Phone (___) ____-_____
Employer: _____ Occupation: _____
Address if different from patient:_____
_____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment reminders, recall notices, billing statements, practice notices and patient portal notifications please list their preferences here:_____
_____

Additional Contact Questions:

Who should receive billing statements?_____

Emergency Contacts <u>other than parents:</u> (please provide name and relationship)

1. _____ Phone: _____
2. _____ Phone: _____

Medical information about patient may be shared with the following people:
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____

If parents are divorced or separated please fill out this section:
*Who has custody?*_____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

*If yes, please explain and provide a copy of any legal paperwork that supports this restriction:*_____