NEW PATIENT REGISTRATION

Name: _____ **DOB:** _____ **Today's Date:** _____

SSN: _____ **Sex:** M F **Marital Status:** Single Married Divorced Widowed

Primary Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____
For notification of test results can we leave a voice mail message? YES NO Initial _____

E-mail: _____
For test results, billing, chart notes can we send you an E-mail? YES NO Initial _____

Employer: _____ **Employer Phone:** _____

Race (please circle)**:** White Black/African American American/Indian/Alaska Native Asian
Native Hawaiian/Pacific Islander Other Decline
Ethnicity (please circle)**:** Hispanic/Latino NOT Hispanic/Latino Decline

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Emergency Contact 1: _____**Relationship** _____ **Phone:** _____

Emergency Contact 2: _____**Relationship** _____ **Phone:** _____

I give Emurgent Care permission to discuss my information with the following: (please circle)
Name: _____ Relationship: _____ Financial Medical

Name: _____ Relationship: _____ Financial Medical

Primary Insurance _____ **ID #** _____

Subscriber's Name _____ **DOB** _____

Subscriber's Address _____

Subscriber's Phone # _____ **Relationship to Patient** _____

Secondary Insurance _____ **ID #** _____

Subscriber's Name _____ **DOB** _____

Subscriber's Address _____

Subscriber's Phone # _____ **Relationship to Patient** _____

Patient Signature: _____

Legal Guardian/Representative Signature: _____