Patient Registration & History

Date: _____ **Signature** of Patient, Parent, Guardian: _____

First Name: _____ **Middle Name:** _____

Last Name: _____ **Called Name:** _____ **Suffix:** _____

Mailing Address: _____

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

Birthdate: _____ **Sex:** ☐ M ☐ F **Age:** _____ **SSN:** _____

Cell Phone: _____ **Other Phone:** _____

Occupation: _____ **Work Phone:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ **Birthday:** _____

Whom may we thank for referring you? _____

Race (check one)

☐White ☐Black/African American ☐Hispanic ☐American Indian/Alaskan Native
☐Asian ☐Asian Indian ☐Chinese ☐Filipino
☐Japanese ☐Korean ☐Vietnamese ☐Native Hawaiian or other Pacific Islander
☐Samoan ☐Guamanian or Chamorro ☐Other ☐I choose not to specify

Multi-Racial (check one): ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language (check one)

☐English ☐Spanish ☐Chinese ☐French ☐German ☐Italian ☐Russian
☐Polish ☐Korean ☐Vietnamese ☐Tagalog ☐Arabic ☐Portuguese ☐Japanese
☐Greek ☐Hindi ☐Persian ☐Urdu ☐Gujarati ☐Armenian ☐French Creole
☐American Sign Language ☐I choose not to specify

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