PATIENT REGISTRATION

Patient's Given Name: _____
(First) (Middle) (Last)

Preferred Name: _____

Address: _____
(Apt #) (City) (State) (Zip)

Gender Assigned at Birth (check one): M _____ F _____ Identifies As: M _____ F_____ Other _____

Preferred Pronouns (check one): He/Him _____ She/Her _____ They/Them _____ Other _____

Date of Birth: _____ Social Security # _____

Cell Phone #: _____ Home/Alt Phone #: _____

Email Address: _____

Preferred Method of contact (check one): Phone _____ Email _____

(Checking email will require being on the Follow My Health patient portal)

Emergency Contact: _____ Relationship: _____ Phone #: _____

Insurance Name: _____ ID: _____

How did you hear about our clinic? _____

SIGNATURE_____ DATE: _____

If you are signing on behalf of the patient, please state your relationship_____