Sample: New Patient Registration Form

Patient Information

First Name:	Middle:	Last:	Other Names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( )	Cellular/Work Phone #: ( )	E-Mail:		
Date of Birth: / /	Social Security Number: - -	Gender: Male Female	Preferred Language:	

Marital Status: Single In a relationship Married Divorced Separated Widowed

Race (circle all that are applicable): White African American American Indian Asian Pacific Islander

Ethnicity: Hispanic or Latino Non-Hispanic Other

Special Population Designation: Please answer the following questions in order for us to better serve you.

1. In the last 2 years, have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, worked with animals like cows, chickens, etc. ☐Yes ☐No
2. In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)? ☐Yes ☐No
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)? ☐Yes ☐No
4. Are you currently living with friends or family, in your car, in a shelter, in a hotel or on the street? ☐Yes ☐No
5. Are you a U.S. Veteran? ☐Yes ☐No
6. Are you living in Public Housing? ☐Yes ☐No

Insurance Information (Please present your insurance card)

Type(s) of Health Care Coverage:	Private Insurance Medicaid Medicare SCHIP None Other:	
Primary:	ID #:	Group #:
Secondary:	ID #:	Group #:

Is your visit due to a(n): Auto Accident? Yes No Job Related injury? Yes No

Person Responsible (Must be an adult over 18 years old)

First Name:	Middle:	Last:
Date of Birth: / /	Social Security Number: - -	Relation to Patient:

Employment Information

Head of Household:			
Employer:			
Employer's Address:	City:	State:	Zip:
Telephone: ( )	Driver's License Number:		

Emergency Contact Information

Person to contact in case of an emergency:	Telephone: ( )
Address:	Relation to the Patient:

Other Family Members

First Name:	Initial:	Last Name:	Gender:	Date of Birth	Social Security #:	Insurance Information:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that I am financially responsible for all charges, whether covered or paid by said insurance. Should ***[name of health center]*** participate with my insurance plan all co-payments and co-insurance payments are due at the time services are rendered. I hereby assign to ***[name of health center]*** all insurance benefits to which I am (or my child is) entitled, including but not limited to Medicare, Private Health Insurance, and any other form of coverage paying benefits. I hereby authorize ***[name of health center]*** to release all necessary information to secure payment.

Date:_____ Name (Print):_____ Signature:_____