Please review and update the information below to the best of your ability.

Patient Registration

Current Patient Information – please print

Last Name: ____________________

First Name: ____________________

Middle Name: ____________________

Address: ____________________

City: ____________State: ______Zip:__________

Home Phone: (__________) ________ - __________

Work Phone: (__________) ________ - __________

Mobile Phone: (__________) ________ - __________

Sex assigned at birth: ____________________

Date of Birth: ____________________

Social Security Number: ____________________

Patient email: ____________________

Contact preference (circle one): **Home phone | Work phone | Mobile phone | Portal | Email**

Primary Language: ____________________

Race: ____________________

Ethnicity: (circle one): **Mexican/Mexican American/Chicanx | Puerto Rican | Cuban Hispanic/Latinx**

Other Hispanic/Latinx | Not Hispanic/Not Latinx | Decline to Specify

Guarantor Information (to whom statements are sent)

Parent 1/Legal Guardian's Name: ____________________

Maiden Name (if applicable): ____________________

Relationship to patient: ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Phone: (__________) ________ - __________

Email: ____________________

Address: ____________________

City: ____________State: ______Zip:__________

Parent 2/Legal Guardian's Name: ____________________

Maiden Name (if applicable): ____________________

Relationship to patient: ____________________

Social Security Number: ____________________

Date of Birth: ____________________

Phone: (__________) ________ - __________

Email: ____________________

Address: ____________________

City: ____________State: ______Zip:__________

Emergency Contact Information

Name: ____________________

Relationship to patient: ____________________

Phone: (__________) ________ - __________

Pharmacy Information

Pharmacy Name: ____________________

Pharmacy Address: ____________________

City: ____________State: ______Zip:__________

Phone: (__________) ________ - __________

Primary Insurance Information

Insurance Plan Name: ____________________

Policy Number: ____________________

Group Number: ____________________

Patient Relationship to Policy Holder (circle one):**Parent/Legal Guardian | Child**

Secondary Insurance Information

Insurance Plan Name: ____________________

Policy Number: ____________________

Group Number: ____________________

Patient Relationship to Policy Holder (circle one): **Parent/Legal Guardian | Child**

To the best of my knowledge the above information is complete and accurate.

Signed____**Date:**____________________