Patient Registration Form

Patient's Legal Name:	Marital Status: M S W D Sep	Gender: ☐ Male ☐ Female	Social Security Number: ______-_____-________

Patient's Date of Birth: ____/____/______	Street Address (including city, state, & zip code):	Home phone: Cell phone: Work phone:

Mailing Address (☐ check if same as street address):

Employer's name / address (for patient or parent if patient is a minor):

Who is the patient's Primary Care Physician?	Who referred the patient to this clinic?

Email Address:	Preferred Language:

Race (please check one): ☐ American Indian or Native Alaskan ☐ Caucasian ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Other: ____________	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Nearest Contact Person(s)	Relationship to Patient	Phone Numbers: ______-______-________ ______-______-________
If patient is a minor, who may authorize medical treatment?	Relationship to Patient	Phone Numbers: ______-______-________ ______-______-________

Insurance Company	Primary:	Secondary:
ID Number		
Subscriber Name		
Subscriber DOB		
Subscriber SSN		
Subscriber Address		
Employer/Group #		

May we leave a message:

At your home?	☐No	☐ Yes, *Brief* or *Extended*
On your cell phone?	☐No	☐ Yes, *Brief* or *Extended*
At your work?	☐No	☐ Yes, *Brief* or *Extended*

What pharmacy would you like to use, if necessary?	I have received a copy of Notice of Privacy Practices (please initial one) NO ________ YES ________

I authorize Peninsula Allergy and Asthma Center to release to the named insurance company(s) any information that is necessary to expedite insurance payment. I have received a copy of Peninsula Allergy and Asthma Center's Financial Policy and understand that I am responsible for all charges, regardless of insurance coverage.

Responsible Party Signature	Relationship to Patient	Date	Time
Address of Responsible Party	Phone	SS#	Date of Birth
Witness Signature	Date	Time	