Adult Patient Registration Form

Adult Patient

Patients Last Name	First Name	Middle Initial

Date	Social Security Number	Preferred Name **Optional**:	Primary Care Provider

Home Address	Email Address

City	State	Zip	Mobile Phone

Date of Birth	Preferred Language	Religion	Alternative Phone

Legal Sex (Circle One)	Race	Marital Status
Female Male Unknown		

Sex Assigned at Birth (Circle One)

Female Male Unknown Not recorded on Birth Certificate Choose not to disclose Uncertain

Gender Identity (Circle One) **Optional**

Female Male Non-Binary Other Transgender Female/ Male to Female Transgender Male/ Female to Male

Sexual Orientation (Circle One) **Optional**

Asexual Bisexual Choose not to disclose Don't Know Lesbian Gay Something Else Straight (not lesbian or gay)

Employer	Employer Address	Work Phone

Employment Status: Circle One

Full Time Part Time Not Employed Active Duty Military Retired Self Employed Student: Full Time / Part Time

Emergency Contact Information

Name	Relationship to Patient

Home Address	Phone Number

City	State	Zip	Alternative Phone

NOTICE OF CREDIT BALANCE REFUND POLICY

As part of our ongoing effort to minimize administrative costs associated with billing and collecting charges for the professional services of our physicians, credit balance refunds of less than $5.00 are not processed for patients who have not received services in our healthcare network for greater than 12 consecutive months (unless specifically requested by the patient within such 12 month period).

Pediatric Patient Registration Form

Pediatric Patient

Patients Last Name	First Name	Middle Initial

Date	Social Security Number	Preferred Name **Optional**	Primary Care Provider

Home Address	Email Address

City	State	Zip	Mobile Phone	Alternative Phone

Date of Birth	Preferred Language	Marital Status	Race	Religion

Legal Sex (Circle One)

Female Male Unknown

Sex Assigned at Birth (Circle One)

Female Male Unknown Not recorded on Birth Certificate Choose not to disclose Uncertain

Gender Identity (Circle One) **Optional**

Female Male Non-Binary Other Transgender Female/ Male to Female Transgender Male/ Female to Male

Sexual Orientation (Circle One) **Optional**

Asexual Bisexual Choose not to disclose Don't Know Lesbian Gay Something Else Straight (not lesbian or gay)

Person Responsible for Bill/Person who carries the Insurance

Name	Relationship to Patient

Home Address	Social Security Number	Date of Birth

City	State	Zip	Phone Number	Alternative Phone

Employer	Employer Address

Emergency Contact Information

Name	Relationship to Patient

Home Address	Phone Number

City	State	Zip	Alternative Phone

NOTICE OF CREDIT BALANCE REFUND POLICY

As part of our ongoing effort to minimize administrative costs associated with billing and collecting charges for the professional services of our physicians, credit balance refunds of less than $5.00 are not processed for patients who have not received services in our healthcare network for greater than 12 consecutive months (unless specifically requested by the patient within such 12 month period).