

PATIENT REGISTRATION DATA

Patient's Legal Name:		Date of Birth	Sex: Male Female	Pronouns:
Addresses (including City, State, and Zip Code): Mailing			Home phone:	
Physical:			Cell phone:	
Email Address:			Work phone:	
			Social Security Number - -	
Preferred Language:		Hearing Impaired: Y / N	Visually Impaired: Y / N	Needs Interpreter: Y / N
Marriage Status: S M W D Sep	Race: (please check one): ☐ American Indian ☐ Black or African American ☐ Native Alaskan ☐ Native Hawaiian ☐ Asian ☐ Other Pacific Islander ☐ Caucasian	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino		
Religion:				
(For Patient or Parent) Employer's Name: _____ Occupation: _____				
Employment Status: (Circle One) Full Time Part Time Not Employed Student Disabled Retired				
Who is the patient's Primary Care Physician?		If retired, please list your retirement dates _____ and your spouse's retirement date _____		
Emergency Contact Person(s)		Relationship to Patient	Phone Number: Phone Number:	
Emergency Contact Person(s)		Relationship to Patient	Phone Number: Phone Number:	
If patient is a minor, who may authorize treatment?		Relationship to Patient	Phone Number: Phone Number:	
Guarantor's Name (If other than self)		Guarantor Date of Birth:	Sex: M F Pronouns:	Social Security Number - -
Relationship to Patient:	Mailing Address (Including City, State, and Zip Code)			Home phone: Cell phone: Work phone:
Insurance Company	Primary:		Secondary:	
I.D. Number				
Subscriber Name				
Subscriber DOB				
Subscriber SSN				
Subscriber Address				
Employer/Group #				
Co Payment Amt				

I authorize Central Peninsula Hospital to release to the named insurance company(s) any information that is necessary to expedite insurance payment. I 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	Witness Signature	
SSN	DL#	DOB#	Date
			Time

