Patient Registration Information

Patient Demographics: Please complete the following information regarding the patient being seen today.

Patient Full Name:	Patient AKA: Note: *Please list all names used in the past or present*
Contact Preference: Home/Mobile/Work/Email	Male or Female Marital Status: M S W D
Date of Birth:	Social Security Number:
Address:	Zip: City: State:
Home # Mobile # Work #	Email Address:
Pharmacy Name/City/Zip Code:	Language: English/Spanish/Other: Hispanic Origin: Yes/No Race:
Do you consent to Texts? Phone Calls?	Patient Portal? If yes, provide email address above

Subscriber Information/Responsible Party: Please complete the following information regarding the person financially responsible.

Name:	Relationship to Patient: Same as patient? Yes/No
Employer Name:	Employer Address/City/Sate:
SSIN:	Date of Birth:

Emergency Contact: Please complete the following information regarding the person(s) to contact in case of an emergency:

Name: _____Relationship: _____Phone: _____

Insurance Information: Please complete the following information regarding your insurance coverage.

Primary Insurance:	Secondary Insurance:
Policy/ID No.: Group No.:	Policy/ID No.: Group No.:
Subscriber Name: Relationship to Patient: Self/Other:	Subscriber Name: Relationship to Patient: Self/Other:

I attest that the information on this form is accurate to the best of my knowledge. I also acknowledge that all lab work ordered (if not performed by our office), will be sent out to Mako Medical Laboratories and I will receive a separate bill for those services.

_____ _____

Patent/Responsible Party Signature *Date*

Revised: June 2021