# 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).