# Patient Registration

**Date:** ______________**Reason for this visit:**_______________________________________________

Is this work related? [ ] YES [ ] NO Is this Auto Accident related? [ ] YES [ ] NO

**Last Name:** _________________________________**First Name:** __________________________**MI:** _____

**SS#:**___________-_________-_______________ **DOB:** ____________________ **Sex:** [ ] Male [ ] Female

**ADDRESS:** (If P.O. Box please provide street address also)

Street: ___________________________________________________________________________________

City: _________________________________________________ State: ________Zip:__________________

Home Phone: ____________________Cell: ______________________Email: ________________________

**Preferred Method of contact:** [ ] Home [ ] Cell [ ] Email Marital Status: _______________

**Employer:** (If Workers Comp)_______________________________________Phone:__________________

**Employer's Address:**___________________________________________________________________

_________________________________________________________________________________________

**Race:** [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American
[ ] Pacific Islander/Hawaiian Native [ ] White [ ] Decline [ ] Other______________

**Ethnicity:** [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Decline

**Preferred Language**: __________________

**Primary Physician:** _____________________________________________Phone# ___________________

**Referring Doctor:** ______________________________________________Phone#____________________

**Medical Insurance:**

Primary: ________________________Secondary:_______________________Other:___________________

Policy Holder: _______________________________________SSN:__________________DOB:___________

Address:___________________________________________________________________________________

_________________________________________________________________Relationship:_______________

**Emergency Contact:**_____________________________________________Relationship:________________

**Emergency Contact Phone:** Home:____________________________Cell:_____________________________

**If patient a minor, Parent/Guardian:** ____________________________________Phone: _______________

**How did you hear about us?** [ ] Doctor Referral [ ] Friend/Family [ ] Insurance Directory
[ ] Internet [ ] Mailer [ ] Newspaper [ ] Phone Book [ ] Signage [ ] Website [ ] Other:____________

**Please indicate the lab your Insurance Company uses:**
[ ] Quest [ ] Lab One [ ] Labcorp [ ] Wuesthoff [ ] Health First

**Your Pharmacy:**_____________________________________________ [ ] I prefer printed prescriptions

## Health Insurance Information:

A copy of your insurance card(s) will be scanned to your file. If proper insurance information is not provided on the date of service, you will be responsible for back charges. It is your responsibility to be aware of the medical benefits your insurance provides

I understand that I am responsible for any bill I receive from the lab.

**Patient/Guardian Signature:**___________________________________________**Date:**_____________