PATIENT REGISTRATION – *Please Print Clearly*

Today's Date:	

Patient Name First Middle Last				Date of Birth	Age
Home Address	Apt. No.	City	State	Zip Code	
Race: ☐ White ☐ African-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other:				E-mail:	
Occupation	Employed ☐ Retired ☐ Student ☐ FT ☐ PT	Social Security No.	Martial Status ☐ S ☐ M ☐ D ☐ W	Sex	Home Phone
Employer (or previous employer, if retired)	Employer's Address			Work Phone	
Spouse (or Parent) Name	Spouse (or Parent) Employer			Spouse (or Parent) Work Phone	
Spouse (or Parent) Address	Apt. No.	City	State	Zip Code	
Name of Person to Contact in Case of Emergency:	Relationship	Home Phone		Work Phone	

How did you hear about us: ☐ Friend ☐ Family ☐ Advertisement: ☐ Physician:

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR DEPENDENT

Parent or Guardian Name First Middle Last				Date of Birth	Age
Address (If different than Patient)	Apt. No.	City	State	Zip Code	
Work Phone	Home Phone	Social Security No.			

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name			ID or Policy Number			Group Number		
Date Effective	Insurance Company's Address		City	State	Zip Code	Policyholder's Name (If other than patient)		
Policyholder's Social Security	Sex	Policyholder's Date of Birth	Policyholder's Address			City	State	Zip Code
Relationship to Patient		Home Phone			Work Phone			
Is this through: ☐ Employer ☐ Individual		Name of Employer			Is policyholder still working? ☐ Yes ☐ No			

SECONDARY INSURANCE

Insurance Company Name			ID or Policy Number			Group Number		
Date Effective	Insurance Company's Address		City	State	Zip Code	Policyholder's Name (If other than patient)		
Policyholder's Social Security	Sex	Policyholder's Date of Birth	Policyholder's Address			City	State	Zip Code
Relationship to Patient		Home Phone			Work Phone			
Is this through: ☐ Employer ☐ Individual		Name of Employer			Is policyholder still working? ☐ Yes ☐ No			

Luan Q. Pho, M.D.