Registration Form

☐ ADDRESS CHANGE
☐ INSURANCE CHANGE

Patient Information

Name: First: ______ MI: ______ Last: ______ **Primary PH #:** ( ) ______
Address: ______ **Secondary PH #:** ( ) ______
City: ______ State: ______ Zip: ______
Sex: ❑M ❑F Age: ______ Birthdate: ______ **SSN**: ______
❑Married ❑Widowed ❑Single ❑Minor ❑Separated ❑Divorced ❑Other
Email:______
Employer/School: ______ Occupation: ______ Phone: ______
Emergency Contact: ______ Relationship: ______ Phone: ______

Additional Information~ Minor Only

Mother: ______ Mother's Cell: ______
Father ______ Fathers Cell: ______
Who does child reside with? ______

PRIMARY DOCTOR:		**Phone:**	
ADDRESS:		**FAX:**	

REFERRING DOCTOR:		**Phone:**	
ADDRESS:		**FAX:**	

How did you hear about Touro Health Center? ☐ Billboard ☐ Health Fair ☐ Insurance Co ☐ Mailer ☐ Newspaper ☐ PCP Referral ☐ Radio ☐ TV ☐ Other Please explain______

Race/ Ethnicity: ☐ Caucasian ☐ Hispanic/Latin ☐ African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Other **Your Primary Language:** ☐ English ☐ Spanish ☐ Other

Primary Insurance (If you do not have insurance please check one of the following:) ☐**Cash Pay** ☐**I Do Program** ☐**AHN** ☐**Volunteers of Southern NV**

Subscriber: ______ Relation to Patient: ______
Birthdate: ______ SSN: ______ Phone: ______
Address (if different from patient): ______
Employer: ______ Occupation: ______ Business Ph: ______
Insurance Company: ______
Insurance Address: ______
Insurance Phone: ______ Subscriber #: ______ Group #: ______

Secondary Insurance

Subscriber Name: ______ Relation to Patient: ______
Birthdate: ______ SSN: ______ Phone: ______
Address (if different from patient): ______
Employer: ______ Occupation: ______ Business Ph: ______
Insurance Company: ______
Insurance Address: ______
Insurance Phone: ______ Subscriber #: ______ Group #: ______

______
Signature of Patient, Parent, Guardian or Personal Representative **Date**

______
Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

Registered By:	