PERSONAL AND FAMILY HEALTH

CLIENT REGISTRATION

Client Information:

Last Name:		First Name:	Middle Initial:
Date of Birth:		Gender: ☐ Male ☐ Female	
Maiden Name:		Social Security Number:	
Telephone Number: (home) (work) (message/cell)			
Mailing Address:		Email Address:	
City:	State:	Zipcode:	County:
Physician Name/Address/Phone:			

Insurance:

- ☐ Public –(UPHP, Medicaid, HMP)
- ☐ Military Health
- ☐ Private - (BCBS, Aetna, Golden Rule)
- ☐ None

Insurance Information:

Policy Number:_____

Name of Policy Holder**:** _____

Insured's Date of Birth:_____

Patient Relationship to Policy Holder:

☐Self ☐Spouse ☐Dependent

What is your Ethnicity? ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown

What is your Race? ***(Please select all that apply)***:

☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown

Employment Information:

☐ Full-time ☐ Part-time ☐ Unemployed

☐ Child ☐ Student ☐ Retired

Family Information:

What is your family size?_____

Income Information:

What is your yearly household income? _____

Responding to this question is optional

What is your marital status?:

☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Child (under 18)

Client Signature: _____ Date: _____