Patient Registration Form

LEGENT

Patient Information (please print)

PATIENT DEMOGRAPHICS

Last Name		**First Name**		**Middle Name**	
Date of Birth	**Gender** *(check one)* ☐ Male ☐ Female	**Social Security #**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Address *(Street or PO Box)*		**Apt/Unit**	**City**	**State**	**Zip**
Home Phone #	**Cell Phone #**	May we contact you by email? ☐ Yes ☐ No	**Email Address**		

Religious Preference *(check one)* ☐Declined ☐Non-Denominational ☐ Baptist ☐Catholic ☐ Christian ☐ Jehovah Witness
☐ Jewish ☐ Methodist ☐ Muslim ☐ Presbyterian ☐ Pentecostal ☐ Other: _____

Race *(check one)*
☐ American Indian or Alaska Native ☐ Asian/Pacific Islander ☐ African American ☐ White ☐ Other

Ethnicity ☐ Hispanic ☐ Non-Hispanic	**Active Military?** ☐ Yes ☐ No	**Place of Birth** *(State is sufficient)*	**Language** *(check one)* ☐ English ☐ Spanish ☐ Other:_____
Do you use smokeless tobacco? ☐ No ☐ Decline ☐ Yes: ☐ Chew ☐ Snuff ☐ Moist Powder		**Current or Former Smoker?** *(*year is sufficient)* ☐ Never Smoked ☐ Decline ☐ Yes, Current; Start Date:_____ ☐ Daily ☐ Some Days ☐ Yes, Former; Start Date:_____ Stop Date:_____	
Employer Name	**Employer Address**		**Employer Phone#**
Was this a work-related injury? ☐ No ☐ Yes – Date of Injury:_____		**Primary Care Physician Name & Phone #**	

GUARANTOR

Guarantor (Responsible Party) ☐ **Check if Same as Patient**

Guarantor Name (Last, First, Middle)			**Relationship to Patient**		
Gender *(check one)* ☐ Male ☐ Female	**Date of Birth**	**Social Security #**	**Home Phone #**	**Cell Phone #**	
Address *(Street or PO Box)*		**Apt/Unit**	**City**	**State**	**Zip**
Employer Name	**Employer Address**			**Employer Phone #**	

CONTACTS

Emergency Contact 1		**Emergency Contact 2**	
Emergency Contact Name	**Relationship:** ☐ Spouse ☐ Parent ☐ Sibling ☐ Son/Daughter ☐ Other: _____	**Emergency Contact Name**	**Relationship:** ☐ Spouse ☐ Parent ☐ Sibling ☐ Son/Daughter ☐ Other: _____
Phone #		**Phone #**	

INSURANCE INFORMATION

Primary Insurance (please provide insurance card) ☐ **Check if patient is Primary Insured**

Subscriber's Name	**Subscriber's DOB**	**Subscriber's SNN**	**Relationship to Patient**	**Gender** ☐ Male ☐ Female
Subscriber's Address	**Apt/Unit**	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Employer Name**	**Employment Status** ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed	

Secondary Insurance (please provide insurance card) ☐ **Check if patient is Primary Insured**

Subscriber's Name	**Subscriber's DOB**	**Subscriber's SNN**	**Relationship to Patient**	**Gender** ☐ Male ☐ Female
Subscriber's Address	**Apt/Unit**	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Employer Name**	**Employment Status** ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed	