INITIAL REGISTRATION

PLEASE COMPLETE ALL INFORMATION

Patient / Client Name (Last, First, Middle Initial)	Sex:	Date of Birth	Social Security Number

Race: **(Check all that apply)**

__American Indian
__Alaska Native
__Asian
__Black or African-American
__Chinese
__Filipino
__Japanese
__Korean
__Vietnamese
__Native Hawaiian
__Pacific Islander
__White/Caucasian

Ethnicity:

___Hispanic
___Non-Hispanic

Marital Status:

__Single
__Married
__Divorced
__Separated

Language:

To better serve you and maintain your confidentiality, we need to know the best ways to contact you.

May we contact you by mail?: ____YES ____NO

Physical Address:

Mailing Address (If Different):

______________________________ ______________________________

______________________________ ______________________________

May we contact you by phone? ____YES ____NO

Primary Phone: (_________)______________________________ Home___ Cell___

Alternate Phone: (_________)______________________________ Home___ Cell___

Other Phone: (_________)______________________________ Home___ Cell___

E-Mail Address:____

Insurance: ___Medicaid ___Medipass ___Medicaid HMO ___Medicare ___Uninsured ___Private Insurance:____________________

Does client have immunization records here?: Yes___ No___ N/A___

I certify that the above information is a true and complete statement to the best of my knowledge.

____ ____________________

Client Signature (If under age 18, Parent / Guardian Signature) **Date**

[Client Label]