Patient Registration Form

PATIENT

Last Name	First Name	MI	DOB

Preferred Name	Gender ☐ Male ☐ Female ☐ Other	SSN

Address	Apt/Unit #	City	State	Zip

Primary Phone	Type ☐ Cell ☐ Family Member ☐ Home ☐ Message Phone ☐ Work ☐ Neighbor	Secondary Phone	Type ☐ Cell ☐ Family Member ☐ Home ☐ Message Phone ☐ Work ☐ Neighbor

E-Mail	Preferred Method of Contact ☐Phone ☐Mail ☐Email ☐Text ☐Patient Portal ☐No Preference

Marital Status ☐Single ☐Married ☐Divorced ☐Other	Primary Language	Interpreter Needed ☐ Yes ☐ No	Religious Preference ☐Christian ☐Jewish ☐Muslim ☐None ☐Other

Ethnicity Hispanic/Latino ☐Yes ☐No ☐Declined	Race ☐African American ☐Caucasian ☐Hawaiian/Pac. Island ☐Asian ☐American Indian /Alaskan Native ☐Declined ☐ Other	Military Status ☐ Active Duty ☐ Retired ☐Declined ☐ Never Served ☐ Other _____

Primary Care Physician Name (PCP)	Phone	Address

How did you hear about UNLV Medicine?
☐Doctor ☐Family/Friend ☐Insurance ☐Internet ☐School ☐Other_____

Emergency Contact Name	Contact Number	Relationship to Patient

Secondary Emergency Contact Name	Contact Number	Relationship to Patient

Employment Status ☐Employed ☐Not Employed ☐Retirement	Employer	Date of Retirement (If applicable)

GUARANTOR (financially responsible)

Last Name (Parent/Guardian #1)	First Name	SSN	Relationship to Patient ☐Self ☐Mom ☐Dad ☐Other

DOB	Address	City	State	Zip

Last Name (Parent/Guardian #2)	First Name	SSN	Relationship to Patient ☐Self ☐Mom ☐ Dad ☐ Other

DOB	Address	City	State	Zip

Primary Phone	Type ☐ Cell ☐ Home ☐ Work ☐ Other	Secondary Phone	Type ☐ Cell ☐ Home ☐ Work ☐ Other

PRIMARY INSURANCE

Insurance Company Name	Insurance ID / Certificate #	Group #

Effective Date	Covered Through ☐ Current Employer ☐ Retirement ☐ Cobra ☐ Other	Name of Employer

Subscriber's Last Name	Subscriber's First Name	DOB

Gender ☐ Male ☐ Female ☐ Other	SSN	Relationship to Patient ☐ Self ☐ Mom ☐ Dad ☐ Other

SECONDARY INSURANCE

Insurance Company Name	Insurance ID / Certificate #	Group #

Effective Date	Covered Through ☐Current Employer ☐Retirement ☐Cobra ☐Other	Name of Employer

Subscriber's Last Name	Subscriber's First Name	DOB

Gender ☐Male ☐Female ☐Other	SSN	Relationship to Patient ☐ Self ☐ Mom ☐ Dad ☐Other

Please ensure that areas in grey are completed
Please use black Ink