

Patient Information:				
Name (Last, First, Middle):		DOB:	Legal Sex: M F	Gender Identity: M F
Preferred Name:		Social Security Number:		
Street Address:		City, State, Zip:		Home Phone:
Mailing Address: (If different from above)		City, State, Zip:		Cell Phone:
Email:		Primary Language:	Interpreter? Y N	Hearing Impaired? Y N
Marital Status:	Religion:	Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Hispanic <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiracial <input type="checkbox"/> Refused		Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino
Guarantor Type: <input type="checkbox"/> Personal/Family <input type="checkbox"/> WC <input type="checkbox"/> TPL <input type="checkbox"/> Confidential <input type="checkbox"/> Facility		Guarantor Relationship to Patient:		Guarantor DOB:
Guarantor Address:		Phone:	Primary Care Provider:	Phone:
Employer Name:		Phone:		
Primary Insurance:				
Name of Insurance:		Name of Insured (Last, First, Middle):		
Policy #:	Group #:	DOB:	Social Security #:	
Claims Mailing Address:		Employer:		
City, State, Zip:	Phone:	Employer Address:		
Relationship to Patient:	Effective Date:	City, State, Zip:	Phone:	
Secondary Insurance:				
Name of Insurance:		Name of Insured (Last, First, Middle):		
Policy #:	Group #:	DOB:	Social Security #:	
Claims Mailing Address:		Employer:		
City, State, Zip:	Phone:	Employer Address:		
Relationship to Patient:	Effective Date:	City, State, Zip:	Phone:	
Emergency Contact:				
Name (Last, First, Middle):		Relationship to Patient:		
Home Phone:	Cell Phone:	Work Phone:	Alternative Phone:	

Bryan Health

**BRYAN HEALTH CLINIC
REGISTRATION RECORD**



Place Patient Label Here