

Patient Information:			
Name (Last, First, Middle):		DOB:	Legal Sex: M F
Preferred Name:		Gender Identity:	
Street Address:		Social Security Number:	
Mailing Address: (If different from above)		City, State, Zip:	Home Phone:
Email:		Primary Language:	Interpreter? Y N
Marital Status:		Religion:	
Race:		Hearing Impaired? Y N	
<input type="checkbox"/> American Indian/Alaskan Native		<input type="checkbox"/> Asian Indian	
<input type="checkbox"/> Guamanian or Chamorro		<input type="checkbox"/> Black/African American	
<input type="checkbox"/> Other Pacific Islander		<input type="checkbox"/> Chinese	
<input type="checkbox"/> Japanese		<input type="checkbox"/> Decline to Answer	
<input type="checkbox"/> Samoan		<input type="checkbox"/> Filipino	
<input type="checkbox"/> Korean		<input type="checkbox"/> Other	
<input type="checkbox"/> Unknown		<input type="checkbox"/> Other Asian	
<input type="checkbox"/> Vietnamese		<input type="checkbox"/> White	
<input type="checkbox"/> White			
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 Address:		Guarantor DOB:	
Phone:		Primary Care Provider:	
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