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:** ☐ Asian ☐ Black/African American ☐ American Hispanic ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Multiracial ☐ Refused	**Ethnicity:** ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Guarantor Type: ☐ Personal/Family ☐ WC ☐ TPL ☐ Confidential ☐ 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