Registration & Change of Information Form

Please NOTE: All questions are important. We only ask what we need to know or what is required by the Complete ALL boxes writing "n/a" in a box that is not applicable

First Name	Mi									
		iddle	Last I	Name		Suffix			Salutation	
						Jr S	r III _	n/a	Mr Mrs Ms	s Dr
Date of Birth	Sex Assigned	Gender I	dentity*	Sexual Orient	ation*	S	ocial Sec	urity#	Marital Status	S
	at Birth									
	F M								Single Mar	ried
Street Address				•	City, State	e ZIP				
Email Address (<u>t</u>	o activate your	patient porta	l account)				Preferre	d Language	e* (note: staff o	only speaks English)
							English	Spanis	h	
Home Phone		Cell Phone (accept text? Yes No)				hone			Contact Prefe	rence
									Email	Home Phone
									Cell Phone	
Reminder Pre	ference: Te	xt Cell Ca	ll Home	Call Email	Occupa	ation:				(□ retired)
Race (census bureau category)* Ethnicity*					Emergency Contact Name, Relationship, Telephone					
White Black or African American Not-Hispanic										
White Hispanic	•	Hispanic or Latino								
Unknown Other U**Gender Identity, Sexual Orientation, Race,				nown						
				Family Medicino						e address)
Name: N				ivairie	Name:			141/1		
Mame.			M/F DOR		Name				M/F	
мате:		I	M/F DOB:		Name				M/F	DOB:
Name: Responsible Par			M/F DOB:		Name				M/F	
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