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Patient Registration

Last Name: _____, First Name: _____, Middle_____

Date of Birth: _____, Age: _____, Gender: ____Male, ____Female

Marital Status: __Single, __Engaged, __Married, __Divorced, __Widow, __Others

Race: __American Indian/Alaska Native, __Asian, __Black/African American, __White

__Native Hawaiian/Pacific Islander, __ Unknown, __Prefer not to answer

Ethnicity of Hispanic/Latino: __Yes, __ No, __Prefer not to answer

Do you speak English? __Yes, __No. If no, what language do you speak_____

Home Address: _____

City: _____ Zip Code: _____

Social Security Number: _____ Cell Phone _____

Home Phone: _____Work Phone: _____

Email: _____Occupation: _____

Employer Name/Address: _____

Person to contact in case of emergency: Name: _____

Phone: _____Relationship: _____

Primary Insurance: _____

Are you the insurance subscriber? _____Yes, _____ No.

If no, subscriber Name: _____Relationship: _____

Social Security Number: _____, Date of Birth: _____

ID#: _____Group#: _____Co-Pay: _____

Secondary insurance if available: _____ ID#: _____

Pharmacy most frequently used: _____Address: _____

How did you hear about us? __Friend/family recommendation, ____Insurance list, __Other:

_____

What made you decide to visit us?

___Location, ___Office hour, ___Dissatisfied with previous doctor, ___Language,

___Other: _____

I hereby authorize Raymond Zhou, M.D., P.C. to release any information necessary to process my insurance claim and direct my carrier to issue payment directly to Raymond Zhou, M.D., P.C. I understand that I am fully responsible for any charges denied by my insurance. I hereby acknowledge that I have received a copy of Notice of Privacy Practices. I also give permission to retrieve my medication usage information to avoid duplication and drug-to-drug interaction.

Patient Signature: _____ Date: _____