SOUTHERN CLINIC, P.C.

# Registration Form

Date: _____

**Please print legibly.**

| | | | | | |
|---|---|---|---|---|---|
| Patient's Name: | | | Date of Birth: | Age: | Sex: |
| Address: | | | City: | State: | Zip: |
| Home Phone #: | Work Phone #: | Cell Phone #: | Email Address: | | |
| Marital Status:<br>☐ Married<br>☐ Single<br>☐ Divorced<br>☐ Widowed | Race:<br>☐ White<br>☐ Black<br>☐ Asian<br>☐ American Indian<br>☐ Other | Ethnicity:<br>☐ Hispanic/Latino<br>☐ Not Hispanic/Latino | Primary Language:<br>☐ English<br>☐ Spanish<br>☐ Other | Primary Phone #:<br>☐ Home<br>☐ Work<br>☐ Cell | |
| SSN#: | Referred By: | | | | |
| Emergency Contact: | Phone #: | Relationship: | | | |
| Patient Employer: | | | Phone #: | | |
| Spouse's Employer: | | | Phone #: | | |
| Primary Insurance: | | | Insurance #: | | |
| Secondary Insurance: | | | Insurance #: | | |
| Preferred Pharmacy: | Preferred Communication Method:<br>Phone Call:<br>☐ Home<br>☐ Work<br>☐ Cell<br>Other:<br>☐ Email<br>☐ Text Message | | | | |

**I certify that this information is true and complete to the best of my knowledge.**

_____ _____ _____

Patient's Signature | Preparer's Signature | Date