



**Registration Form**

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

(Number and Street Name)

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)

**Phone number:** \_\_\_\_\_

(Primary)

(Secondary)

**E-mail address:** \_\_\_\_\_

•By providing your e-mail address you can have access to our web-based patient portal. This portal allows you to view all of your test results and visit information on-line. This option is strongly encouraged for all our patients. Your e-mail address will never be solicited by any other company.

**Marital Status** (please circle one):    Single    Married    Widowed    Divorced

**SPOUSE INFORMATION:**

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

(Primary Number)

(Secondary Number)

**Social Security Number:** \_\_\_\_\_

**Parent Information:** (If patient is under 18 or insurance is in parent's name)

**Father or Guardian**

**Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Mother or Guardian**

**Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**IN CASE OF EMERGENCY, Please give name, address and phone number of a friend or a relative not living at your address:**

**Name:** \_\_\_\_\_ **Relation to you:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Race** (please circle one):    Asian    American Indian    Caucasian    Prefer not to disclose

**Ethnicity** (please circle one):    Hispanic    Non-Hispanic    Prefer not to disclose