One On One
MEDICAL CARE

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PATIENT'S REGISTRATION FORM

Patient's Information # _____

First Name _____ Last Name _____ Middle Name _____

Date of Birth: (mm/dd/yyyy) _____

Sex: ☐ male ☐ female

Social Security Number _____

Address:

Street | Apt _____ City | State | Zip _____

Phone:

Home| Cell | Work _____

Marital Status:

☐ Married ☐ Widowed ☐ Separated
☐ Divorsed ☐ Single ☐ Partner

Language:

☐ English ☐ Greek ☐ Chinese
☐ Spanish ☐ French ☐ Mong
☐ Armenian ☐ Persian ☐ Korean
☐ Russian ☐ Indian ☐ Japanese
☐ Italian ☐ German ☐ Other
☐ Arabic ☐ Ukraine _____

Race:

☐ American or Alaskan Native ☐ Black or African American ☐ Asian
☐ Native Hawaiian or Pacific Is. ☐ White or Caucasian ☐ Other

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Emergency Contact:

First Name _____ Last Name _____

Phone #: _____

Relationship to Patient: _____

Address:

Street | Apt _____ City | State | Zip _____