CARLS CENTER FOR CLINICAL CARE AND EDUCATION
CENTRAL MICHIGAN UNIVERSITY

MR# _____
For office use only

PATIENT REGISTRATION

Date: _____ Legal Name: _____
(Last) (First) (MI)

Preferred Name: _____ Gender: ☐ Male ☐ Female Date of Birth: _____

Permanent Address: _____
(Street) (P.O. Box) (City) (State) (Zip)

Alternate Address: _____
(Street) (P.O. Box) (City) (State) (Zip)

Phone: _____ Alternate Phone: _____

Email: _____ Marital Status: _____

Preferred Language: _____ Preferred Written Language: _____

Ethnicity (choose one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Prefer not to answer

Race (choose one):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White or Caucasian
☐ Other
☐ Unknown
☐ Prefer not to answer

Employment Status: _____ Spouse Employment Status: _____

How did you hear about the Carls Center? _____

Primary Care Physician (PCP): _____ PCP Phone #: _____

PCP Address: _____

APPROVED/EMERGENCY CONTACTS

(Please provide the following information on someone we can speak with on your behalf. This will only be changed upon written request.)

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____ Emergency Contact: ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____ Emergency Contact: ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION

(If patient is a minor or has a guardian, please complete this section.)

Parent/Guardian Name: _____ Gender: _____ Date of Birth: _____

Address: _____
(Street) (P.O. Box) (City) (State) (Zip)

Phone Number: _____ Alternate Phone: _____

Email: _____ Name of Employer (if applicable): _____

Patient: _____ Date of Birth: _____

RESPONSIBLE FINANCIAL PARTY INFORMATION (If different than patient)

Responsible Party Legal Name: _____

Gender: _____ Date of Birth: _____ Email: _____

Address: _____
(Street) (P.O. Box) (City) (State) (Zip)

Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION

If you have Medicare insurance is it due to age or disability? (check one) ☐ **Age** ☐ **Disability**

Primary Insurance: _____

Cardholder's Name: _____

Cardholder's Date of Birth: _____ Gender: _____

Relationship to Patient: ☐ Child ☐ Parent ☐ Self ☐ Spouse ☐ Other: _____

ID# from Insurance Card: _____ Group #: _____

Secondary Insurance: _____

Cardholder's Name: _____

Cardholder's Date of Birth: _____ Gender: _____

Relationship to Patient: ☐ Child ☐ Parent ☐ Self ☐ Spouse ☐ Other: _____

ID# from Insurance Card: _____ Group #: _____

Other Insurance: _____

Cardholder's Name: _____

Cardholder's Date of Birth: _____ Gender: _____

Relationship to Patient: ☐ Child ☐ Parent ☐ Self ☐ Spouse ☐ Other: _____

ID# from Insurance Card: _____ Group #: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

My signature below acknowledges that I have been offered a copy of the *NOTICE OF PRIVACY PRACTICES* for the Carls Center for Clinical Care and Education.

I understand that it is my right to receive this information and it is in my best interest to read and inquire about any privacy issues or concerns that I may have.

_____ _____
Signature of Patient, Parent, or Guardian Date:

_____ _____
Print Name Relationship to Patient