CARLS CENTER FOR CLINICAL CARE AND EDUCATION
CENTRAL MICHIGAN UNIVERSITY

PATIENT REGISTRATION

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

Preferred Name: _____ Gender: _____ Date of Birth _____

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

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

Phone #: (_____)_____ Alternate Phone: (_____)_____

Email: _____ Patient's Marital Status: _____

Preferred Language: _____ Preferred Written Language: _____

Ethnicity: (choose one)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Prefer not to answer

Race: (choose all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian
- ☐ Multiple
- ☐ Other
- ☐ Unknown
- ☐ Prefer not to answer

Family Doctor's Name: _____ Employment Status: _____

Family Doctor's Address: _____ Spouse Employment Status: _____

Family Doctor's Phone #: (_____) _____ How did you hear about the Carls Center? _____

What is your preferred method of communication? (mark all that apply) Mail ☐ Phone ☐ Text ☐ Email ☐ MyChart ☐

APPROVED/EMERGENCY CONTACT

(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 Code)

Phone: (_____) _____ Alternate Phone: (_____) _____

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

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Patient Name: _____ 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 Code)

Phone #: (_____) _____ Alternate Phone #: (_____) _____

INSURANCE INFORMATION

If you have Medicare insurance is it due to age or disability? (mark one) age ☐ disability ☐

Primary Insurance: _____

Cardholder's Name: _____ Gender: _____

Cardholder's Date of Birth: _____ Relationship to Patient: (circle) Child☐ Parent☐ Self☐ Spouse☐ Other _____

ID # from Insurance Card: _____ Group #: _____

Secondary Insurance: _____

Cardholder's Name: _____ Gender: _____

Cardholder's Date of Birth: _____ Relationship to Patient: (circle) Child☐ Parent☐ Self☐ Spouse☐ Other _____

ID # from Insurance Card: _____ Group #: _____

Other Insurance: _____

Cardholder's Name: _____ Gender: _____

Cardholder's Date of Birth: _____ Relationship to Patient: (circle) Child☐ Parent☐ Self☐ Spouse☐ Other _____

ID # from Insurance Card: _____ Group #: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT 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.

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

Relationship
_____ **to Patient**: _____
Print Name