Stanford HEALTH CARE

University HealthCare Alliance

Patient Registration Form

Thank you for choosing our office. In order to serve you properly, we will need the following information. ***Please print.*** *All information is strictly confidential.*

PATIENT NAME _____ PRIMARY LANGUAGE SPOKEN _____
(LAST) (FIRST) (MI)

ADDRESS _____
(STREET) (APT.) (CITY) (STATE) (ZIP)

HOME PHONE (_____)_____ WORK PHONE (_____) _____ EXT. _____

CELL PHONE (_____)_____ OTHER (_____)_____

EMPLOYER _____ EMP STATUS: FT PT STUDENT(FT or PT) RETIRED NOT EMPLOYED

SEX: MALE FEMALE BIRTHDATE _____ / _____ / _____ SSN _____

E-MAIL _____ I agree to communicate with my provider's office via e-mail: YES NO

PRIMARY CARE PHYSICIAN_____ DRIVER'S LICENSE # _____

RACE: AFRICAN AMERICAN ASIAN CAUCASIAN NATIVE AMERICAN OR ALASKA NATIVE
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER OTHER_____ DECLINE TO STATE

ETHNICITY: HISPANIC/LATINO NON-HISPANIC/NON-LATINO DECLINE TO STATE

RELIGIOUS PREFERENCE: _____ DECLINE TO STATE

MARITAL STATUS: SINGLE MARRIED LIFE PARTNER WIDOWED DIVORCED SEPARATED

RESPONSIBLE PARTY INFORMATION

Complete if patient is not responsible party or if patient is a minor.

RESPONSIBLE PARTY_____ SSN _____
(LAST) (FIRST) (MI)

ADDRESS _____
(STREET) (APT.) (CITY) (STATE) (ZIP)

EMPLOYER _____EMP STATUS: FT PT STUDENT(FT or PT) RETIRED NOT EMPLOYED

INSURANCE INFORMATION

Please complete below, AND give office copies of your cards.

PRIMARY INSURANCE _____ ID # _____

GROUP # _____ PROVIDER ON CARD _____

INS. ADDRESS _____
(STREET) (SUITE) (CITY) (STATE) (ZIP)

POLICY HOLDER _____ DOB_____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMP STATUS: FT PT STUDENT(FT or PT) RETIRED NOT EMPLOYED

SECONDARY INSURANCE_____ ID # _____

GROUP # _____ PROVIDER ON CARD _____

INS. ADDRESS _____
(STREET) (SUITE) (CITY) (STATE) (ZIP)

POLICY HOLDER _____ DOB_____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMP STATUS: FT PT STUDENT(FT or PT) RETIRED NOT EMPLOYED

EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY #**1** _____

RELATIONSHIP _____ PRIMARY PHONE #: (_____)_____, HOME / MOBILE / WORK

SECONDARY PHONE #: (_____)_____, HOME / MOBILE / WORK

PERSON TO NOTIFY IN CASE OF EMERGENCY #**2**_____

RELATIONSHIP _____ PRIMARY PHONE #: (_____)_____, HOME / MOBILE / WORK

SECONDARY PHONE #: (_____)_____, HOME / MOBILE / WORK

FOR OUR MINOR PATIENTS

CHILD PRIMARILY LIVES WITH: (please specify)_____

PARENT #1 INFORMATION

PARENT NAME _____ RELATIONSHIP TO PATIENT _____
(LAST) (FIRST) (MI)

BIRTHDATE _____ / _____ / _____ SSN _____

ADDRESS _____
(STREET) (SUITE) (CITY) (STATE) (ZIP)

HOME PHONE (_____)_____ WORK PHONE (_____) _____ EXT. _____

CELL PHONE (_____)_____ OTHER (_____)_____

PARENT #2 INFORMATION

PARENT NAME _____ RELATIONSHIP TO PATIENT _____
(LAST) (FIRST) (MI)

BIRTHDATE _____ / _____ / _____ SSN _____

ADDRESS _____
(STREET) (SUITE) (CITY) (STATE) (ZIP)

HOME PHONE (_____)_____ WORK PHONE (_____) _____ EXT. _____

CELL PHONE (_____)_____ OTHER (_____)_____

SIBLING NAMES (if any)

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

NO SHOW POLICY

As a patient in our Practice, it will be your responsibility to keep scheduled appointments. Our office requires notification of cancellation at least 24 hours prior to the appointment or earlier if possible. Please contact our office to cancel and reschedule an appointment.

The Practice will consider a "failed appointment" anytime a patient has not given the advance notice above. A No Show charge will be applied to your account if advance notice is not given. The charge will range from $25.00/$100.00 depending on the type of appointment missed.

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

SIGNATURE

I have read and agreed to the above for University HealthCare Alliance. I have reviewed and confirm that the information provided is correct.

_____ _____
PATIENT/GUARDIAN/PATIENT REPRESENTATIVE SIGNATURE RELATIONSHIP TO PATIENT

PRINT NAME (if other than patient) _____ DATE _____