# PATIENT REGISTRATION FORM


**Patient Information:**

Name (last, first, middle initial): _____

Today's Date: _____ Preferred Name: _____Age: _____Date of Birth: _____

Sex: ☐ Male ☐ Female Email: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: Home (_____) _____ Cell (_____) _____ Work (_____) _____

How did you hear about our clinic? _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Volunteer

Employer: _____ Occupation: _____ # of Hrs Work: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone #: (_____) _____

**Demographics:**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Living: ☐ Alone ☐ w/ Partner/Spouse ☐ w/ Parents ☐ w/ Children ☐ w/ Other Family Members ☐ w/ Friends

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ More than one race ☐ Declined ☐ Hispanic ☐ Other: _____

Ethnicity: ☐ American ☐ Asian Indian ☐ Caribbean Islander ☐ Chinese ☐ Eastern European ☐ Filipino
☐ Japanese ☐ North African ☐ Middle Eastern ☐ Korean ☐ West African ☐ Vietnamese
☐ Parkistani ☐ Declined ☐ Other_____

**Insurance Information:**

Primary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No
Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

**Insured Information (if other than patient): We will request to scan your ID and insurance card.**

Subscriber/Policy Holder: _____ Relationship to Patient: _____
Address: _____
Social Security Number: _____ Date of Birth: _____ Subscriber Employer: _____

Inova TCM reserves the right to charge a fee for any scheduled visits that are:
1. Cancelled less than 24 hours of appointment
2. Missed without calling to cancel (No-Show)
Cancellation Fee Schedule: New Patient & Established Patient - $45.00

Patient/Parent/Guardian Signature: _____ Date: _____ Time: _____

**Please indicate your referring doctor as well as other doctors who will need information about your treatment.**

Primary Care MD Name: _____ Tel: _____ Fax: _____

Specialty Care MD Name: _____ Tel: _____ Fax: _____

Specialty Care MD Name: _____ Tel: _____ Fax: _____