



Registration Form: (Please print clearly & fill form completely)

TO BE COMPLETED BY PATIENT

PATIENT INFORMATION 18 – 22 YEAR OLDS	
LAST NAME:	FIRST NAME:
PREFERRED NAME:	DATE OF BIRTH:
PATIENT PHONE #:	OK to leave detailed voicemail: Yes / No
PATIENT EMAIL:	OK to send text messages: Yes / No
LANGUAGE:	ADDRESS:
RACE(S):	
ETHNICITY: <input type="radio"/> Hispanic or <input type="radio"/> Non-Hispanic	EMPLOYER:

PATIENT RESIDES WITH			
<input type="radio"/> Both Parents -same house	<input type="radio"/> On Own	<input type="radio"/> Mother	<input type="radio"/> Father
<input type="radio"/> Both Parents - separate houses			
FIRST CONTACT INFORMATION (after patient, if any)		SECOND CONTACT INFORMATION (after patient, if any)	
Name:		Name:	
Relationship:		Relationship:	
Financially Responsible? Yes / No		Financially Responsible? Yes / No	
Address (if different):		Address (if different):	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
OK to leave detailed message? Yes / No		OK to leave detailed message? Yes / No	
OK to text cell phone? Yes / No		OK to text cell phone? Yes / No	
E-Mail:		E-Mail:	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Employer:		Employer:	

INSURANCE INFORMATION	
Insurance Company:	Effective Date:
Policy ID #:	Policy Group #:
Policy Holder Name:	Policy Holder Date of Birth:

EMERGENCY CONTACT		
Name:	Relationship:	Phone:

I CONFIRM THAT THE ABOVE INFORMATION IS COMPLETED ACCURATELY	
Printed Name	
Signature	Date

TURN OVER FOR INFORMATION RELEASE AUTHORIZATION →

REVISED 5/27/2026

