NEW PATIENT REGISTRATION / UPDATED INFORMATION

IMPORTANT: You will be asked to present a photo ID and have your photo taken for your electronic patient chart.

ARROYO VISTA
FAMILY MEDICINE

Patient's Legal Name:	**Sex:** ☐ Male ☐ Female	**Date of Birth (DOB):**
Mailing Address:		
Physical Address: ☐ Same as Mailing Address		
Other Address (if you reside outside of the RGV during other times of the year)**:**		**Date range at this address:**
Personal Cell Phone Number:		
Primary Care Doctor/Clinic (if applicable)**:**	**Primary Care Doctor/Clinic Contact Information** (if outside of RGV)**:**	
OB/GYN (if applicable)**:**	**OB/GYN Contact Information** (if outside of RGV)**:**	
How did you hear about us?		

Social Security Number:	**Occupation:**
Employer:	**Business Phone:**
Employer Address:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced	
Which best describes your race? ☐ American Indian or Alaska Native ☐ Asian (Including Indian subcontinent origins) ☐ Black or African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Other:_____ ☐ Decline **Do you consider yourself Hispanic/Latino?** ☐ Yes ☐ No ☐ Decline	

Emergency Contact's Name:	**Emergency Contact's Phone Number:**
Relationship to Patient:	**May we discuss medical information with this contact <u>ONLY</u> in the event of an emergency situation?** ☐ Yes ☐ No
Preferred Hospital (ONLY to be used in the event of an emergency)**:**	

I hereby verify that all information on this form is true and correct to the best of my knowledge.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**