

## Custer County Clinic Patient Registration

DATE: \_\_\_\_\_

<b>Patient:</b> <i>Last</i> <i>First</i> <i>MI</i>			<b>SSN:</b>
<b>Mailing Address:</b>		<b>Street Address:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>	
<b>Male/Female:</b>	<b>DOB:</b>	<b>Employer:</b>	<b>E-Mail:</b>
<b>Preferred Language:</b>	<b>Race/Ethnicity (circle one):</b> >Asian    >Native Hawaiian >Other Pacific Islander    > Black/African American (not Hispanic or Latino) >American Indian/Alaska Native    >White (not Hispanic or Latino) >Hispanic or Latino (all races)		

**EMERGENCY CONTACTS** *(No Private Health Information Provided):*

<b>Emergency Contact #1:</b>	<b>Phone No.:</b>	<b>Cell No.:</b>	<b>Relationship:</b>
<b>Emergency Contact #2:</b>	<b>Phone No.:</b>	<b>Cell No.:</b>	<b>Relationship:</b>

**BILLING INFORMATION** *(Please give insurance cards to receptionist):*

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
<b>Private Pay: (Yes or No)</b>	<b>Billing Address: (if different than above)</b>