PATIENT REGISTRATION FORM

(Please print clearly)

First Name: _____ MI: _____ Last: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ SS#: _____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Email May we leave a message? ☐ Yes ☐ No

Gender: ☐ M ☐ F Marital Status: _____ Preferred Language: _____

Race: ☐ White
☐ Black/ African American
☐ Asian
☐ American Indian/ Alaskan Native
☐ Native Hawaiian/ Pacific Islander
☐ Other

Are You: ☐ Hispanic/ Latino
☐ Non Hispanic/ Latino

Responsible Party (if different from patient) **Must be completed if patient is a minor.

First Name: _____ MI: _____ Last: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Relationship to Patient: _____

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.

Name: _____ Relation: _____ Phone #: _____ ☐ Yes ☐ No

Name: _____ Relation: _____ Phone #: _____ ☐ Yes ☐ No

Patient/Guardian Signature: _____ **Date:** _____

Blue Water Surgery Center **6830 S US Highway 1 Port St. Lucie, FL 34952** **Phone: 772-873-6700 / Fax: 772-465-5499**	**Patient Label Here** **Revised: 06/23/2015**