Date ____________________

PATIENT REGISTRATION FORM
Oakland General Surgery

PATIENT INFORMATION

Last Name ______________________ First ______________________ MI ______

Address ______________________________________ Apt. #________

City ______________ ST______ ZIP______ E-mail address______________

Home Phone______________ Cell Phone Work Phone______________

Date of Birth____________ Sex: Male ☐ Female ☐ Age________ SS#__________

Marital Status: Single Married ☐ Widowed ☐ Divorced ☐

Preferred Language: English ☐ Other ________ **Ethnicity:** Hispanic ☐ Latino ☐ Not Hispanic or Latino ☐

Race: African American or Black ☐ American ☐ American Indian or Alaskan ☐ Asian ☐ Native Hawaiian or Other ☐

Other Race ☐ White ☐

Patient Employed By______________________ Occupation______________________

Employer Address______________________ City__________ State________ Zip________

Business Phone______________, Ext.______ If student, school name______________

Is student: Full Time ☐ Part Time ☐

GUARANTOR/SPOUSE INFORMATION (if not above)

Name ______________________ Relationship______________ Phone Number ______________

Address ______________________ City ______________ ST______ Zip

Date of Birth ____________ Sex: Male ☐ Female ☐ Age______ SS#________

REFERRING PHYSICIAN

Physician's Name______________________ Phone Number______________

Address ______________________ City ______________ ST______ Zip ________

PRIMARY CARE PHYSICIAN IF DIFFERENT FROM REFERRING PHYSICIAN

Physician's Name______________________ Phone Number______________

Address ______________________ City ______________ ST______ Zip ________

Emergency Contact Name______________________ Relationship to You ______________

Work Phone Number ______________ Home Phone N mber ______________

Is the injury / illness related to work? Yes☐No☐If yes, date of injury__________

Is the injury / illness due to an accident? Yes☐No☐If yes, date of injury__________

Type of Accident Motor Vehicle (MVA) Other (please explain)______________

Referral Source: Family ☐ Friend ☐ Insurance Company ☐ Phone Book ☐ Other ☐

Name and Address of referral source:______________________________

Can we leave appointment reminders on the home number provided? Yes ☐ No ☐

Can we contact you via e-mail? Yes ☐ No ☐ Can we text to your cell phone? Yes ☐ No ☐