Date ____/____/____

OAKLAND GENERAL SURGERY

PATIENT REGISTRATION FORM

Acct # ____________

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 ______________

Emergency Contact Name ______________________ Relationship to You ______________

Work Phone Number ______________________ Home Phone Number ______________________

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 ☐