MONTESOL MEDICAL CENTERS

Patient Registration Form

Demographic Information

First Name: _____ **M.I.:** _____
Last Name: _____
DOB: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone No.: (_____)_____ **Cell:** (_____)_____
Email: _____
SSN: _____

Sex: ☐ Male ☐ Female ☐ Unknown
Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown
☐ Widowed ☐ Legally Separated
Preferred Language: ☐ English ☐ Spanish; Castilian ☐ Sign Languages
☐ Declined to specify ☐ Haitian/ Haitian Creole
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to report
Race: ☐ Black ☐ Declined to specify ☐ Other race ☐ White ☐ African American
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander
Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Not Employed
☐ Self-employed ☐ Retired ☐ On active military duty ☐ Reserved for national assignment
☐ Unknown

Advanced Directive: ☐ PA - Power Attorney ☐ LW - Living Will
*If YES to either, please provide a copy to the front desk

Emergency Contact Information

Name: _____
Relationship to Patient: _____
Address: _____
Phone No.: (_____)_____

Preferred Pharmacy Contact Information

Name: _____
Address: _____
Phone Number: (_____)_____