SUN LIFE FAMILY HEALTH CENTER
REGISTRATION FORM

(Please Print)

☐ New Pt ☐ Est Pt
Date
Acct No

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:

Mailing Address:	City:	State:	Zip:
Street Address:	City:	State:	Zip:

Home Phone No: ( )	Cell or Message Phone No: ( )	Work Phone No: ( )	Date of Birth:
Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		Gender: ☐ Male ☐ Female

(for statistical reporting purposes only)

Race: ☐ American Indian/Alaska native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White (including Whites of Latino/Hispanic descent) ☐ More than one race ☐ Other

Ethnicity: ☐ Hispanic ☐ Non Hispanic	Language Spoken: ☐ English ☐ Spanish ☐ Hearing impaired ☐ Other	Do you require Translation? ☐ Yes ☐ No	Are you a Veteran of the USA Armed Forces? ☐ Yes ☐ No

Family Size:	Yearly Income:	How did you hear about us? ☐ Friend/patient ☐ Insurance ☐ Hospital ☐ Physician ☐ Newspaper ☐ Yellow Pages ☐ Other _____

E-mail address:	Where else do you regularly receive medical care?
Agricultural Work Status: ☐ Non ☐ Seasonal ☐ Migrant ☐ Yearly	Student Status (18yrs and over) if yes where? ☐ Full Time ☐ Part Time

Employed: ☐ Yes ☐ No ☐ Retired ☐ Self Employed	Occupation:	Employer Name: _____ Address: _____ City: State: Zip:

SPOUSES INFORMATION

Spouses Last Name:	Spouses First Name:	MI:

Spouses Social Security Number:	Spouses Date of Birth:	Gender: ☐ Male ☐ Female

Employed: ☐ Yes ☐ No ☐ Retired ☐ Self Employed	Occupation:	Employer Name: _____ Address: _____ City: State: Zip:
	Work Phone No: ( )	

EMERGENCY CONTACT

Local friend or relative (not living at same address): Name: _____ Address: _____ City: State: Zip	Home Phone No: ( ) Message Phone No: ( )

GUARANTOR OR RESPONSIBLE PARTY

(Needs to be completed by parent or legal guardian
For children under the age of 18 years old)

Last Name:	First Name:	Middle Initial:
Mailing Address:	City:	State: / Zip:
Home Phone No: / Work Phone No:	Social Security Number:	Date of Birth:

Gender:
☐ Male
☐ Female

Occupation:

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Do you currently have medical or dental insurance?
☐ Yes ☐ No If yes, please provide copy of insurance card.

Medical Insurance Primary:	Medical Insurance Secondary:	Dental Insurance:
Name of Insured:	Name of Insured:	Name of Insured:
Insured SS #:	Insured SS #:	Insured SS #:
Insured Date of Birth:	Insured Date of Birth:	Insured Date of Birth:
Patient's Relationship to Insured:	Patient's Relationship to Insured:	Patient's Relationship to Insured:

IMMEDIATE FAMILY MEMBERS SEEN HERE

First Name _____ Last Name _____ Date of Birth _____ Gender____

First Name _____ Last Name _____ Date of Birth _____ Gender____

First Name _____ Last Name _____ Date of Birth _____ Gender____

First Name _____ Last Name _____ Date of Birth _____ Gender____

First Name _____ Last Name _____ Date of Birth _____ Gender____

First Name Last Name Date of Birth Gender

The Above information is true to the best of my knowledge. I authorize SLFHC to use the medical or dental records for the above name individuals for insurance and statistical purposes. Consent for treatment is given for the above named individuals. I acknowledge that payment for services is my responsibility and assign all insurance benefits to Sun Life Family Health Center, Inc.

Patient or Guarantor_____ Date_____