University of Michigan Medical Center

PATIENT REGISTRATION

** You can print this form and make extra copies to use at your site **

DATE: ___/___/___ CLINIC _____

APPOINTMENT TIME: _____

UH REGISTRATION NUMBER:

GENERAL PATIENT INFORMATION

NAME _____ _____
LAST FIRST MIDDLE MAIDEN

TITLE ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.

MARITAL STATUS ☐ Married ☐ Single ☐ Widow ☐ Divorced

ETHNIC GROUP ☐ Am Indian ☐ Black ☐ Oriental ☐ Hispanic ☐ White ☐ Unknown

RELIGION _____ Sex ☐ M ☐ F

PATIENT BIRTH DATE ___/___/___ (MM DD YY) SOCIAL SECURITY ___-___-___

PARENTS NAMES _____ / _____
FATHER'S FIRST / LAST MOTHER'S FIRST / LAST

PATIENT ADDRESS

_____
STREET NUMBER APT#

_____
CITY STATE ZIP

_____
COUNTY OF RESIDENCE CARE OF / OR COUNTRY

( )
TELEPHONE NUMBER

PATIENT / PARENT EMPLOYMENT INFORMATION

EMPLOYER _____

EMP. ADDRESS _____
STREET – NUMBER

_____
CITY STATE ZIP

( )
TELEPHONE NUMBER OCCUPATION

RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Child ☐ Other

NEXT OF KIN / EMERGENCY NOTIFICATION

If next of kin address is same as patient address, please complete name and relationship and check this box. ☐

_____
NAME

_____
STREET NUMBER APT#

_____
CITY STATE ZIP

_____
COUNTY OF RESIDENCE CARE OF / OR COUNTRY

( )
TELEPHONE NUMBER

RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Child ☐ Other

BILL TO ADDRESS

NOTE: CANNOT BE EMPLOYER OR INSURANCE COMPANY
If bill to address is same as patient address, check box ☐

_____
NAME

_____
STREET NUMBER APT#

_____
CITY STATE ZIP

_____
COUNTY OF RESIDENCE CARE OF / OR COUNTRY

( )
TELEPHONE NUMBER

BILL TO EMPLOYMENT INFORMATION

EMPLOYER _____

EMP. ADDRESS _____
STREET – NUMBER

_____
CITY STATE ZIP

( )
TELEPHONE NUMBER OCCUPATION

RELATIONSHIP TO PATIENT

☐ Self ☐ Father
☐ Spouse ☐ Child
☐ Mother ☐ Other

REFERRING PHYSICIAN INFORMATION

1. REFERRING PHYSICIAN ☐ MD ☐ DO

NAME

ADDRESS STREET NUMBER PHONE

CITY STATE ZIP

2. OTHER PHYSICIAN ☐ MD ☐ DO

NAME

ADDRESS STREET NUMBER PHONE

CITY STATE ZIP