PATIENT REGISTRATION FORM

(Please fill out this form completely)

Registration Clerk: _____ Date: _____

Patient Information:

Name (Last, First Middle): _____

Sponsor's SSN: _____ Your SSN: _____ Sex: ☐

Religious Preference: _____ DOB: _____

Ethnicity (check one) ☐ Filipino ☐ Hispanic ☐ Southeast Asian ☐ Asian/Pacific Islander ☐ Other: _____

Race (check one): ☐ Asian ☐ Black ☐ Western Hemisphere Indian ☐ White ☐ Other: _____

Marital Status (check one): ☐ Annulled ☐ Divorced ☐ Interlocutory ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

Home Address: _____

State: Zip Code: Home Phone: ( ) Work Phone: ( )

Emergency Contact Information:

Name (Last, First MI): _____ Relationship: _____

Address: _____

State: _____ Zip Code: _____ Home Telephone: (_____) _____

Next-of-Kin Information:

Name (Last, First MI): _____ Relationship: _____

Address: _____

State: _____ Zip Code: _____ Home Telephone: (_____) _____

Sponsor Information:

Name (Last, First MI): _____ Flying Status: ☐

Service: _____ Rank: _____ MOS/Rate/Designator _____

Command: _____ Length of Service: _____

Duty Address: _____

State: _____ Zip Code: _____ **Duty Telephone:** (_____) _____

Other Health Insurance: *(Please do not include TRICARE)*

Are you covered by private health insurance: ☐ If Yes, please complete DD FORM 2569.

I certify that the information on this form is complete and correct to the best of my knowledge.

_____ _____

Patient Signature Date