PROVIDENCE
St Peter Family Medicine

TRAVEL CLINIC REGISTRATION FORM

PATIENT DEMOGRAPHICS				
LAST NAME, FIRST NAME, MIDDLE NAME			PREFERRED NAME	
SOCIAL SECURITY NUMBER	SEX M / F	DATE OF BIRTH		AGE
MAILING ADDRESS		CITY	STATE	ZIP
PRIMARY CONTACT NUMBER (Circle Method) Home Cell Work	SECONDARY CONTACT NUMBER (Circle Method) Home Cell Work		EMAIL ADDRESS	

GENERAL INFORMATION		
PREFERRED LANGUAGE	Do you need an interpreter? YES / NO	MARITAL STATUS S / M / D / W / O
ETHNICITY HISPANIC OR LATINO / NOT HISPANIC OR LATINO / REFUSE	RACE Alaska Native, American Indian, African American, Asian Caucasian, Native Hawaiian, Pacific Islander, Other, Refuse	
EMPLOYMENT STATUS EMPLOYED / NOT EMPLOYED / RETIRED / STUDENT	EMPLOYER	
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PREFERRED CONTACT NUMBER (Circle Method) Home Cell Work

GUARANTOR Please complete the section below if someone other than the patient is responsible for today's payment.

LAST NAME, FIRST NAME			RELATIONSHIP TO PATIENT
MAILING ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	SEX M / F	DATE OF BIRTH	PRIMARY PHONE (Circle Method) Home Cell
EMPLOYMENT STATUS EMPLOYED / NOT EMPLOYED / RETIRED / STUDENT	EMPLOYER		WORK PHONE

COVERAGES: SELF-PAY

Signature of Patient or Responsible Party	DATE