DESERT OASIS HEALTHCARE
PATIENT REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient Name (Last, First, Middle)			
Email	Birth date:	Age:	Sex:
Home Phone:	Cell Phone: (We use this number for SMS texting)		
Physical Address:			
City:	State:	ZIP Code:	
Mailing Address (if different):			
How do you wish to be contacted? (Please Circle)	Home Number	Cell Number	Patient Portal
Occupation:	Preferred Language:		
Preferred Pharmacy:	City and Cross Street of Pharmacy:		
Race: (Indicate/Select all that apply) African American Black White American Indian Alaska Native Asian Native Hawaiian or other Pacific Islander	Ethnicity: Hispanic or Latino Not Hispanic or Latino		
Emergency Contact Name:	Relationship:		
Emergency Contact Date of Birth:	Emergency Contact Phone:		

BILLING INFORMATION

Please give your insurance card to the receptionist

Person responsible for bill:	Home Phone:
Birth date:	Address (if different from above):
Relationship to patient:	Cell Phone: (We use this number for SMS texting)
Occupation:	
Retired? ❑ Yes ❑ No	
Primary Insurance:	
Medicare ID Number:	
Subscriber's Name:	Birthdate:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Insurance:	ID #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Desert Oasis healthcare or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	Date: