Patient Registration Form

SAN FRANCISCO
VOICE & SWALLOWING
KATHERINE C. YUNG, MD FACS

Today's Date _____ **Medical Record #** (for office use) _____

DEMOGRAPHICS

Patient Name _____
Last Name First Name M.I.

Preferred name (nickname)_____ Date of Birth _____ Age: _____

Social Security #_____ Gender: ☐ Male ☐ Female

Mailing Address _____
street apt # city state zip

Primary Phone (_____)_____ Secondary Phone (_____)_____
☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell

Email: _____

ADDITIONAL GOVERNMENT-REQUESTED INFO

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Decline to state

Race ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Black/African American ☐ White
☐ American Indian/Alaska Native ☐ Other ☐ Unknown ☐ Decline to state

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Preferred Language ☐ English ☐ Spanish ☐ Cantonese ☐ Russian ☐ Other

Needs Interpreter ☐ Yes ☐ No **Appt Reminder Pref:** ☐ Phone ☐ Email

PRIMARY CARE PROVIDER & EMERGENCY CONTACT INFO

Primary Care Provider_____

Referring Provider ***(Who referred you to our practice?)*** _____

Emergency Contacts:

	Primary	**Secondary**
Name	:	
Phone	: ( )	( )
Relationship to Patient	:	
Mailing Address **(optional)**	:	