



Patient Registration Form

Patient information											
Last Name		First Name		Middle Name		Suffix		Social Security #			
Gender (circle) M / F		Date of Birth		Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other				Preferred Language			
Race (check all that apply) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Patient Declined				Ethnicity (check all that apply) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multiple <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Patient Declined							
Mailing Address				Apt/Lot		City/State		Zip code		Phone #s: Home () Mobile () Work ()	
Email Address								Primary Physician			
Responsible Party/Parent/Guardian (circle one)						Check if same as [] Patient					
Last Name		First Name		Gender (circle) M / F		Date of Birth		What is Patient's relationship to responsible party?			
Mailing Address				Apt/Lot		City/State		Zip code		Phone #s: Home () Mobile () Work ()	
Employer Information											
Employer			Address			City/State			Zip code		
Insurance Information						Check if [] Self pay					
Primary Insurance:						Secondary Insurance:					
Insurance Name				Begin date		Insurance Name				Begin date	
Subscriber/Member Name				Date of Birth		Subscriber/Member Name				Date of Birth	
What is Patient's Relationship to Subscriber?			Gender (circle) M / F			What is Patient's Relationship to Subscriber?			Gender (circle) M / F		
Insurance Mailing Address			City/State			Insurance Mailing Address			City/State		
code			Zip			code			Zip		
Subscriber/Member #				Group #		Subscriber/Member #				Group #	
Patient Portal											
<p>To receive an invitation to register for the patient portal please ensure you have provided an e-mail address above.</p> <p>Benefits of the patient portal include: 24/7 access online via a computer or smart phone app for yourself or a designated caregiver to view results and visit summaries, request prescription refills, update your demographics, and send secure messages directly to your provider's staff without having to pick up the phone.</p> <p>To opt out of the patient portal please check one of the options below:</p> <p>_____ I am not interested in signing up for the portal at this time _____ I do not have an e-mail address</p>											
Health Information Exchange (HIE)											
<p>I grant Reno Heart and Vascular Institute consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize Reno Heart and Vascular Institute to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying Reno Heart and Vascular Institute</p>											

Patient/Legal Guardian Signature Date

Patient/Legal Guardian Print Date