

Watauga Surgical Group, P.A.  
PATIENT REGISTRATION FORM  
PLEASE PRINT PLAINLY AND COMPLETE EACH LINE

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

(If PO Box, please list 911 address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_

\*\*\*Secondary Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

(If PO Box, please list 911 address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date-of-Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female

Social Security Number: \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_

\*\*\*Email address: \_\_\_\_\_  Decline to provide

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed (Check one)

Race (please check one)

White  Hispanic  Black or African American  Asian  American Indian or Alaska Native  Other  Decline to provide

Ethnicity (please check one)

Non Hispanic or Non Latino  Hispanic or Latino  Decline to provide

Preferred Language (please check one)

English  Spanish  \_\_\_\_\_ Other

SPOUSE- PARENT (if minor) INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Cell phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_

Employer \_\_\_\_\_ Employer Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

Address \_\_\_\_\_

Street City/State Zip  
Telephone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

MEDICAL INSURANCE *\*Please provide insurance cards*

PRIMARY (Name of Insurance) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other (Check one)

SECONDARY (Name of Insurance) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other (Check one)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date