Metropolitan State University

Patient Registration

This information will be added to your electronic health record. You will be asked to review your contact information once per year. Please let clinic staff know of any changes to your contact information.

Patient Information

Patient Name: First_____ MI _____ Last_____

Preferred Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Prefer not to answer Preferred Pronouns: ☐ she/her/hers ☐ he/him/his ☐they/them/theirs

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Email Address: _____

Parent / Legal Guardian name if applicable: _____ Relationship to patient:_____

Emergency Contact

Please list one person to contact in case of an emergency situation

Name: _____ Relationship to Patient: _____

Phone Number: _____

Our clinic offers discounts for certain populations. Please answer the following questions to determine if you qualify for a discount.

Are you a veteran? ☐ Yes ☐ No

Spouse of a veteran? ☐ Yes ☐ No

Are you over +55? ☐ Yes ☐ No

Are you a Student? ☐ Yes ☐ No