MONUMENT HEALTH

EPATREG

Patient Registration

MRN: _____
CSN: _____ Time of Arrival: _____

Patient Demographics			
Last Name:			**Home Phone:**
First Name:			**Work Phone:**
Middle Name:			**Mobile Phone:**
Sex:	**Date of Birth:**	**Social Security Number:** - -	
Reason for Visit or Chief Complaint:			
Mailing Address:			**City:**
State:	**Zip:**	**Country:**	**Email:**
Copy of Patient ID made: ☐ Yes ☐ No			

General Information	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally-Separated ☐ Widowed	**Needs Interpreter:** ☐ Yes ☐ No
Preferred Language:	**Written Language:**
Race: ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Guamanian or Chamorro ☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ Other Pacific Islander ☐ Other Asian ☐ White ☐ Other:	
Ethnicity: ☐ Mexican, Mexican American, or Chicano/a ☐ Not Hispanic, Latino/a, or Spanish Origin ☐ Cuban ☐ Other Hispanic, Latino/a, or Spanish Origin ☐ Puerto Rican	
Religion:	**Employer:**
Employment Status: ☐ Full Time ☐ Part-Time ☐ Retired ☐ Active Military ☐ Not Employed ☐ Disabled ☐ Self-Employed ☐ Student Full-Time ☐ Student Part-Time	
Primary Care Provider: *(Last Name, First Name)*	
Address: *(if other than Black Hills area)*	**Phone:**

Emergency Contact Information			
Last Name:			**Home Phone:**
First Name:			**Work Phone:**
Relationship to Patient:			**Mobile Phone:**
Mailing Address:			**City:**
State:	**Zip:**	**Country:**	
Last Name:			**Home Phone:**
First Name:			**Work Phone:**
Relationship to Patient:			**Mobile Phone:**
Mailing Address:			**City:**
State:	**Zip:**	**Country:**	