

Primary Care Partners

Account No.		Entered Date
Reg. By		Office Site
<input type="checkbox"/> New <input type="checkbox"/> Change	Info. Change:	

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI _____

Other Name: _____

Marital Status: Single Married Widowed
 Separated Divorced Other

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: Alt Phone Number Email

Letter Phone Call (Cell) Phone Call (Home)

Driver's License # (DL#) _____ State(ST) _____

Emp. Status: Employed Full Time Employed Part Time

Unemployed Disabled Homemaker

Student Active Military Self-Employed Other _____

Language: English Spanish Other _____

Social Security Number: _____

Date of Birth: _____ Sex: M F

Race: (please choose one of the following):

American Indian Asian African American
 Native Hawaiian/Pacific Islander White Other
 Unknown Patient Refused

Ethnicity: Hispanic or Latino Not Hispanic or Latino
 Unknown Other Patient Refused

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: M F

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: M F

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys: _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Pharmacy Name, Address & Phone #: _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Guarantor Information

Please complete if guarantor is other than self. (Guarantor) is the person financially responsible for this patient's bill.)

Guarantor: _____

Patient's Relationship to Guarantor: _____

Addr1: _____

Social Security Number: _____

Addr2: _____

Date of Birth: _____ Sex: M F

City, State, Zip: _____

Home Phone: (_____) _____

Employer: _____

Cell Phone: (_____) _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

Driver's License # (DL#) _____ State(ST) _____

Guarantor E-Mail: _____

Emerg. Cont.: _____

Patient's Relationship to Emerg. Cont.: _____

Home Phone: (_____) _____

Alt Phone: (_____) _____

Cell Phone: (_____) _____

How did you hear about our practice? Billboard Brochure Health Fair Health Plan Internet Mass Mailing
 Newspaper/Magazine Ongoing Care Patient Phone Book Phys. Off/ER Relative Radio TV Word of Mouth Other
