Date: _____

Patient Registration Form

Social Security #: ____-____-____ Patient name: _____

Date of birth: _____ Age: _____ Sex: ☐Female ☐Male

Address: _____ City: _____ State: _____ Zip: _____

Best number for contact: (____) _____

Emergency contact: (____) _____ Name: _____Relationship: _____

*Email address: _____

*Please provide your email so that we can let you know about any insurance changes, health alerts, changes in our clinic hours, new locations, staff members or i-Care services and other important issues. This information will never be provided to a third party.

US FEDERAL GOVERNMENT REQUIREMENT (check one)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Race: ☐American Indian ☐ Asian ☐ African American ☐ Pacific islander/ Hawaiian ☐White ☐ Decline

Preferred language: _____

PRIMARY CARE DOCTOR INFORMATION:

Name: _____ Phone: (____) _____ Fax: (____) _____

PHARMACY PREFERENCE:

Name: _____ Location: _____ Phone: (____) _____

INSURANCE INFORMATION:

Policyholder name:_____ Date of birth:_____.

Patients relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other:_____.

FINANCIALLY RESPONSIBLE PARTY *(Complete this section **ONLY** if different than the patient being seen)*

Name: _____ Date of birth: _____ Social Security #: ____-____-____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us?

☐Insurance Directory	☐Magnet	☐Yelp
☐Employer	☐Family/Friend: _____	☐Hospital referral
☐Doctor referral: _____	☐Signage	☐Flyer
☐Internet	☐Facebook	☐Other: _____