IRMC Physician Group Today's Date:_____

PATIENT REGISTRATION

**All fields marked with an asterisk must be completed*

***Patient Name** _____ _____ ____ _____
Last First M.I. *Date of Birth

***Address** _____ _____ _____ _____
Street / P.O. City State Zip Code

County:_____**Country**:_____**Email:**_____@_____

Home Phone _(_____)_____-_____ **Work Phone:**(____)_____-_____**Cell Phone**: (___)_____-_____

Preferred Communications ☐ Home ☐ Work ☐ Cell

SS# _____/____/_____**Preferred Name**:_____

Drivers License #:_____**State Issued:**_____***Primary Language** ☐ English ☐ Other, Please Specify: _____

Maiden Name (if applicable) _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ ***Gender** ☐ Male ☐ Female ☐ Unknown ☐ Other

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Nat/Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other ☐ Declined

Religion: ☐ Buddhist ☐ Catholic ☐ Hindu ☐ Islamic ☐ Jewish ☐ Protestant ☐ N/A ☐ Unknown ☐ Other

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown ☐ Declined ☐

Employer Name & Address: _____

Work Phone: _____ **Employment Status:** _____**Occupation:**_____

Next of Kin/Person to Notify in Emergency (*Someone not living with you*)

Name_____ Relationship_____Phone _____

INSURANCE INFORMATION

Insurance Company_____ Name of Subscriber_____

Subscriber Employed by_____ Subscriber's SS# _____

Group#_____ Identification#_____ Subscriber's DOB_____

Insurance Plan Code_____ MA Access ID#_____Card Issue_____

Other Insurance_____

Preferred Pharmacy :_____**Phone:**_____

Referred By: ☐ Physician ☐ Friend ☐ Newspaper ☐ Radio ☐ Insurance ☐ Internet ☐ Referred by Patient ☐ Established Patient
If physician, who referred?_____ ☐ Other _____ ☐ IPG Physician ☐ Direct to Consumer

_____ _____
Patient's/Parent or Guardian (if minor) Signature Date