

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 **Religion:** Buddhist Catholic Hindu Islamic Jewish
 Nat/Hawaiian/Pacific Islander White Unknown Other Declined 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