IRMC
PHYSICIAN GROUP
THE COMMUNITY'S CHOICE

Patient Registration Form

* All fields marked with an asterisk must be filled out

*** Patient Name:** _____ (Last) _____ (First) _____ (M.I.) _____ (* Date of Birth)

***Address:** _____ (Street / P.O. Box) _____ (City) _____ (State) _____ (Zip Code)

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

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

Preferred Communication: ☐ Home ☐ Work ☐ Cell

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

Driver's License #: _____ **State Issued:** _____ ***Primary Language:** ☐**English** ☐**Other (Please specifiy):** _____

Maiden Name (if applicable): _____

Marital Status: ☐Single ☐Married ☐Widowed ***Gender:** ☐Male ☐Female ☐Other: _____

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

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

Ethnicity: ☐**Not Hispanic/Latino** ☐**Hispanic/Latino** ☐**Unknown** ☐**Decline**

Employer Name & Address: _____

Employment Status: _____ **Job Title:** _____

Emergency Contact (*Someone outside of permanent residence***)**

Name: _____ **Relationship:** _____ **Phone #:** _____

Insurance Information

Insurance Provider: _____ **Insurance Subscriber:** _____

Subscriber's Employer: _____ **Subscriber's SS #:** _____/_____/_____

Group #: _____ **Identification #:** _____ **Subscriber's D.O.B:** ____/_____/_____

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**
Referring Physician's Name: _____ **Other:** _____ ☐**IPG Physician** ☐**Direct to Consumer**

_____ Patient's/Guardian's (if minor) Signature

_____ Date