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:** __________________________________

**You will receive IRMC Physician Group monthly eNewsletter and gain access to IRMC.me patient portal. Staff will ask you to answer a security question for portal access.*

**Home Phone: (_____)** ______-_________ **Work Phone: (_____)** ______-_________ **Cell Phone: (_____)** ______-_________

**Preferred Communication:** ☐ Home ☐ Work ☐ Cell

**SS #:** _______/______/_________ **Preferred Name:**________________________

**Maiden Name ( if applicable):** ___________________________

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

**Race:** ______________________________________ **Religion:** ______________________________

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

***PCP Name:** ________________________________

*** 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**

## Insurance Information

***Subscriber Name:** _________________________ ***Subscriber's D.O.B:** ____/_____/______

## Emergency Contact Information

***Name:** ________________ **Relationship:** ______________ **Phone #:** _____________ **D/O/B:** _________

***Name:** ________________ **Relationship:** ______________ **Phone #:** _____________ **D/O/B:** _________

## Work Status (if retired)

**Date of Retirement (if applicable):** ____________________________________________________________
**Date of Spouse's Retirement (if applicable):** ____________________________________________________
*This information is required for Medicare.*

_______________________________________ ____________________
Patient's/Guardian's (if minor) Signature Date