PATIENT REGISTRATION

Today's Date ____________________

PATIENT INFORMATION

Patient complete legal name ____ Age _________
First Middle Last

Date of Birth _______________ SS# _________________________ Male ___ Female ___ Marital Status ___________

Address ____
Street and Apt or Lot# City State Zip Code +4

Phone: Land-line________________________ Cell ________________________ Work _________________________

Preferred language _________________________ Race _____________________ Ethnicity __________________

Smoking Status ______________________ Occupation/Employer ____

Emergency Contact Person #1 ____ Relationship ___________________________

Best Contact Phone: ____________________________ (work, cell, home)

Emergency Contact Person #2 ____ Relationship ___________________________

Best Contact Phone: ____________________________ (work, cell, home)

INSURANCE INFORMATION

INSURANCE PLAN NAME __________________________________ Effective Date _______________ Primary ☐ Secondary ☐

Name of Subscriber/Policyholder ____ Gender _______________
First Middle Last

Date of Birth _______________ SS# _________________________ Relationship to Patient _________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Best Contact Phone: ____________________________ (work, cell, home)

INSURANCE PLAN NAME __________________________________ Effective Date _______________ Primary ☐ Secondary ☐

Name of Subscriber/Policyholder ____ Gender _______________
First Middle Last

Date of Birth _______________ SS# _________________________ Relationship to Patient _________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Best Contact Phone: ____________________________ (work, cell, home)

INSURANCE PLAN NAME __________________________________ Effective Date _______________ Tertiary ☐

Name of Subscriber/Policyholder ____ Gender _______________
First Middle Last

Date of Birth _______________ SS# _________________________ Relationship to Patient _________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Best Contact Phone: ____________________________ (work, cell, home)

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment ____
First Middle Last

Date of Birth ______________ SS# ________________________ Relationship to Patient ________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Phone: Land-line________________________ Cell ________________________ Work ________________________

Employer ____

Employer's Address ____
Street City State Zip Code +4

Other Parent's Name____ Date of Birth ______________
First Middle Last

Other Parent's Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Other Parent's Phone: Land-line___________________ Cell ___________________ Work ____________________

For Office Use Only

Information updated in NueMD by ______________________ Date ______________

Information updated in DrFirst by ______________________ Date ______________

MRN ______________________
(For office use only)

Revised 1/14/16.cmf