Family Practice Group, P.C.

Patient Registration Form

PATIENT INFORMATION

Name _____ Gender _____

Address _____ Date of Birth _____

Street Address

_____ Marital Status _____

City, State, Zip

Home Phone ( ) _____ Primary Care Provider _____

(Area Code)

Cell Phone ( ) _____ Social security # _____

(Area Code)

Work Phone ( ) _____ Email address _____

(Area Code)

Race & Ethnicity _____ / _____ Preferred language _____

Race *Ethnicity*

Pharmacy Name _____

Name *Phone*

_____

Street Address *City, State, Zip*

If patient is a minor, who is financially responsible?

Responsible Party Name _____

Address _____ Daytime Phone (_____)_____

Street Address *(Area code)*

_____ Relationship to patient _____

City, State, Zip

INSURANCE INFORMATION (please show all insurance cards to the receptionist)

Primary insurance company _____ Subscriber ID _____

Address _____ Group plan # _____

Street Address

_____ Group name _____

City, State, Zip

Subscriber name _____ Gender *(circle one)* Male Female

Relationship to patient *(circle one)* Subscriber's date of birth _____

Self / Spouse / Parent / Other _____

EMERGENCY CONTACT INFORMATION *(Please list a person whom we may contact in case of emergency)*

Name _____ Relationship _____

Home/Cell Phone ( ) _____ Cell/Work Phone ( ) _____

(Area Code) *(Area Code)*

Address _____

Street Address *City, State, Zip*