Primary Care Partners

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Patient Last Name: _____ Social Security Number: _____

First Name: _____ MI _____ Date of Birth: _____ Sex: ☐ M ☐ F

Other Name: _____ Race: (please choose one of the following):
☐ American Indian ☐ Asian ☐ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Unknown ☐ Patient Refused

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ Other ☐ Patient Refused

Addr2: _____

City, State, Zip: _____ Home Phone: (_____) _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email Alt Phone: (_____) _____

☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home) Home E-Mail: _____

Driver's License # (DL#) _____ State(ST) _____ Cell Phone: (_____) _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time Employer: _____

☐ Unemployed ☐ Disabled ☐ Homemaker Address: _____

☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____ City, State, Zip: _____

Language: ☐ English ☐ Spanish ☐ Other _____ Work Phone: (_____) _____

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRRIER: _____ Telephone #: (_____) _____

Address: _____ ID/Cert #: _____

Group/Plan #: _____ Effective Date: _____ Subscriber's Name: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F Relationship to Patient: _____

SECONDARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ ID/Cert #: _____

Group/Plan #: _____ Effective Date: _____ Subscriber's Name: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F Relationship to Patient: _____

Primary Care Phys: _____ Refer. Phys. (if different): _____

Address: _____ Address: _____

City, St., Zip: _____ City, St., Zip: _____

Telephone #: _____ Telephone #: _____

Pharmacy Name, Address & Phone #: _____