Date of Service:
Service Department:
Time of Check-In:

Patient Label:

## Patient Registration For Established Patients

**Current Patient Information – Please Print**
**(Use Full Legal Name)**

Last Name:
First Name:
Middle Name:
Address:
City, State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Consent to call: (YES or NO) / Consent to text: (YES or NO)
Sex:
Date Of Birth:
Social Security Number:
Patient Email:
Language:
Race:
Ethnicity:
Marital Status:

**Other**

Primary Care Provider:
Contact Preference: (Home/Work/Mobile/Portal/Email)
ICARE: (YES / NO)
Patient Record Sharing: (YES / NO)
Medication History Authorization: (YES / NO)

**Guarantor Information**
**(To Whom Statements Are Sent)**

Name:
Address:

Relationship to patient:
_____
Date Of Birth:
Social Security Number:
Phone: ( ) _____ - _____

**Emergency Contact Information**

Name:
Relationship:
Phone:
Mobile Phone: ( ) _____ - _____

**Employer Information**

Employer:
Address:
Phone:

**Pharmacy Information**

Name:
Phone:

**Primary Insurance Information *(Make a copy of insurance card)**

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City, State, Zip:
Date Of Birth:
Sex: (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

**Secondary Insurance Information *(Make a copy of insurance card)**

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City, State, Zip:
Date Of Birth:
Sex: (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

Today's Payment: $ _____
Patient's condition related to: Employment: ___Other Accident: ___Auto Accident: ___Another Party Responsible: ___
Patient Receiving: Hospice: ___Home Health Services: ___ESRD: ___

**Chief Complaint / Reason For Visit: _____**

Do you have an Advanced Directive? (Yes / No)
Do we have a copy on file? (Yes / No)

**Clinic:**

PCP Last Visit:

**Hospital:**

Attending Provider:
Admitting Provider:
Level Of Care:

Summary of Care: Send to Portal: ____ Paper: ____