

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)

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:
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)

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

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:

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:

Clinic:

PCP Last Visit:

Hospital:

Attending Provider:
Admitting Provider:
Level Of Care: