

INTEGRATED FAMILY MEDICINE

Patient Registration Form

NEW CHANGE

Facility Code: _____

Info change: Name
 Address
 Insurance
 Other

Date: _____

Please Print Clearly

PATIENT INFORMATION					
PATIENT'S NAME:				DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
PATIENT'S ADDRESS: STREET INFO.		CITY		STATE	ZIP
PATIENT'S PHONE #:	S.S. #:	CELL PHONE:		MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
EMPLOYER'S NAME:				EMPLOYER'S PHONE #:	
EMPLOYER'S ADDRESS: STREET INFO.		CITY		STATE	ZIP

EMAIL ADDRESS: _____

RESPONSIBLE PARTY INFORMATION					
NAME:				DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS: STREET INFO.		CITY		STATE	ZIP
PHONE #:	S.S. #:	CELL PHONE:		MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
EMPLOYER'S NAME:				EMPLOYER'S PHONE #:	
EMPLOYER'S ADDRESS: STREET INFO.		CITY		STATE	ZIP

INSURANCE INFORMATION					
PRIMARY INSURANCE COMPANY NAME:			INSURANCE CO. PHONE #:		
POLICY NUMBER:	GROUP NUMBER:		EFFECTIVE DATES:		
INSURANCE COMPANY ADDRESS: STREET INFO.		CITY		STATE	ZIP
NAME OF SUBSCRIBER:	S.S. #:	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> _____			
SUBSCRIBER ADDRESS:			SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX <input type="checkbox"/> M <input type="checkbox"/> F	
SECONDARY INSURANCE COMPANY NAME:			INSURANCE CO. PHONE #:		
POLICY NUMBER:	GROUP NUMBER:		EFFECTIVE DATES:		
INSURANCE COMPANY ADDRESS: STREET INFO.		CITY		STATE	ZIP
NAME OF SUBSCRIBER:	S.S. #:	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> _____			
SUBSCRIBER ADDRESS:			SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX <input type="checkbox"/> M <input type="checkbox"/> F	

EMERGENCY CONTACT / PARENT OR GUARDIAN OF PATIENT					
NAME:					
ADDRESS: STREET INFO.		CITY		STATE	ZIP
TELEPHONE #: HOME: WORK:		RELATIONSHIP TO PATIENT: <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER _____			

PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING