PATIENT REGISTRATION

DATE:

PLEASE PRINT PATIENT INFORMATION

NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)

SS#: _____ BIRTHDATE: _____ AGE: _____ SEX: (M)(F)

MARITAL STATUS - ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED PREFERRED PHARMACY: _____

E-MAIL ADDRESS: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ OCCUPATION: _____ FULL TIME / PART TIME

ADDRESS: _____

PREVIOUS CARE FROM: _____ PHONE#: _____

SPOUSES NAME: _____ PHONE # _____ BIRTHDATE _____

==========

RACE: _____ ETHNICITY: _____ MAIN LANGUAGE SPOKEN IN HOME: _____

EMERGENCY CONTACT: _____ PHONE #: _____ RELATIONSHIP: _____

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RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT: _____
(LAST) (FIRST) (MIDDLE INITIAL)

SS#: _____ BIRTHDATE: _____ AGE: _____ SEX: (M)(F)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ OCCUPATION: _____ FULL TIME ☐ / PART TIME ☐

ADDRESS: _____

MARITAL STATUS - ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED E-MAIL ADDRESS: _____

SPOUSES NAME: _____ PHONE # _____ BIRTHDATE: _____

SPOUSES E-MAIL ADDRESS: _____

INSURANCE INFORMATION

***PRIMARY INSURANCE COMPANY:** _____

POLICY# _____ GROUP# _____ EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____ SS# _____ BIRTHDATE: _____

SUBSCRIBER ADDRESS: _____ PHONE #: _____

***SECONDARY INSURANCE COMPANY:** _____

POLICY# _____ GROUP# _____ EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____ SS# _____ BIRTHDATE: _____

SUBSCRIBER ADDRESS: _____ PHONE #: _____

PLEASE HAVE YOUR INSURANCE CARD(S) READY SO THAT WE MAY SCAN THE INFORMATION INTO YOUR MEDICAL RECORDS

I hereby certify that all of the above information is correct and true and further certify that I am the patient or duly authorized by the patient to legally sign this document. I (patient or responsible party) guarantee payment for any amount due for such services provided by this practice. I authorize CCFP to view my external prescription history via the RX Hub service. This signature will be valid for five (5) years from this date, unless otherwise stated. A photo copy of this document has the same effect as an original copy.

PATIENT SIGNATURE: _____ DATE: _____

Updated 07/18/2013