



Treating You Well.

Registration Form

Last Name		First Name		MI	DOB	Account Number <small>(Office use only)</small>	
Street Address				City		State	ZIP Code
Home Phone		Work Phone		Cell Phone		Social Security #	
Email Address							
Emergency Contact						Contact Phone	
PRIMARY Insurance Name			Copay \$	SECONDARY Insurance Name			Copay \$
Claims Address				Claims Address			
City, State, ZIP				City, State, ZIP			
Subscriber's Name			Subscriber DOB	Subscriber's Name			Subscriber DOB
Subscriber's ID No.			Group No.	Subscriber's ID No.			Group No.
Patient's Relation to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				Patient's Relation to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
How did you hear about our practice? <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Phone Book <input type="checkbox"/> PriMed Website <input type="checkbox"/> Internet <input type="checkbox"/> Signage <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Other Physician <input type="checkbox"/> Hospital							
Please provide the following information so we may improve patient communication and care.							
Primary Language <i>(select one)</i> <input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Bengali <input type="checkbox"/> Chinese <input type="checkbox"/> German <input type="checkbox"/> Hindi (Urdu) <input type="checkbox"/> Japanese <input type="checkbox"/> Mandarin <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish							
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino			Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian				
Complete this section ONLY if the patient is under 18 years old.							
Last Name		First Name		Relationship to Patient			
Street Address				City		State	ZIP Code
Home Phone		Work Phone		Cell Phone		Gender	
The undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.							

Signature _____ Date _____