PriMED PHYSICIANS
Treating You Well.®

Registration Form

Last Name	First Name	MI	DOB	Account Number (Office use only)

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	Patient's Relation to Subscriber
☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other

How did you hear about our practice?
☐ Family ☐ Friend ☐ Newspaper ☐Radio ☐ TV ☐ Phone Book ☐ PriMed Website
☐ Internet ☐ Signage ☐ Insurance Directory ☐ Other Physician ☐ Hospital

Please provide the following information so we may improve patient communication and care.

Primary Language *(select one)*
☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ German ☐Hindi (Urdu)
☐ Japanese ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Spanish

Ethnicity
☐ Hispanic or Latino
☐ NOT Hispanic or Latino

Race
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ 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**_____