ADULT

primarycare HEALTH PARTNERS

PATIENT REGISTRATION FORM

Please fill out both pages of this form as completely as possible.

Section 1: PATIENT INFORMATION

Name: _____
Last First Middle

Other names used (nickname, maiden name): _____

SSN: _____ Date of Birth: _____

Gender: M F Gender at Birth: M F Pronouns (optional): _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Domestic Partner

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Latino or Hispanic
- ☐ Declined

Race:
- ☐ Black, African American
- ☐ Asian
- ☐ White
- ☐ American Indian, Alaska Native
- ☐ Native Hawaiian, Other Pacific Islande
- ☐ Declined

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Genderqueer
- ☐ Other
- ☐ Declined to specify

Sexual Orientation:
- ☐ Straight/Heterosexual
- ☐ lesbian,Gay, Homosexual
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't know
- ☐ Declined to specify

Primary Language spoken: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #s Home: _____ Cell: _____ Cell Carrier: _____ Work: _____

Email: _____

Primary Care Physician (PCP): _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Phone #s Home: _____ Work: _____

CONTINUE, PLEASE FILL OUT PAGE 2 ▸

Section 2: PERSON RESPONSIBLE FOR PAYMENT

Please Note: If the responsible party is the person in Section 1, you may skip this section.

Name: _____
Last First Middle

Other names used (nickname, maiden name): _____

SSN: _____ Date of Birth: _____ Gender: M F

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #s Home: _____ Cell: _____ Work: _____

Email: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____

Section 3: INSURANCE INFORMATION

PRIMARY INSURANCE

Name: _____ Effective Date of Coverage: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____

SUBSCRIBER INFORMATION

Name: _____
Last First

SSN: _____ Date of Birth: _____ Gender: M F

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY INSURANCE

Name: _____ Effective Date of Coverage: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____

SUBSCRIBER INFORMATION

Name: _____
Last First

SSN: _____ Date of Birth: _____ Gender: M F

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

ASSIGNMENT OF INSURANCE BENEFITS/Authorization of Release Records

I hereby authorize Primary Care Health Partners to recover from my insurance payment for any services Primary Care health Partners provides to me. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize Primary Care Health Partners to release all information necessary to secure such payments. A photocopy of this statement is to be considered as valid as the original.

Signed: _____ Date: _____