MRN ______________________
(For office use only)

****PLEASE PRINT – COMPLETE BOTH SIDES****

PATIENT REGISTRATION

Today's Date ______________________

PATIENT INFORMATION

Patient complete legal name ______________________ Age _________
First Middle Last

Date of Birth _______________ SS# __________________________ Male ___ Female ___ Marital Status ___________

Preferred language __________________________ Race ______________________ Ethnicity ___________________

Smoking Status __________________________ Occupation ____

Physical Address ____
Street/Apt or Lot# City State Zip Code +4

Mailing Address or Permanent Address

Address ____
Street/Apt or Lot# City State Zip Code +4

PO Box __________________________________

Phone: Land-line_________________________ Cell _________________________ Work __________________________

Employer ____

Employer's Address ____
Street City State Zip Code +4

Emergency Contact Person #1 ____ Relationship ____________________________

Phone: Land-line_________________________ Cell _________________________ Work __________________________

Emergency Contact Person #2 ____ Relationship ____________________________

Phone: Land-line_________________________ Cell _________________________ Work __________________________

Previous Physician ____ Telephone ______________________________

Address ____
Street City State Zip Code +4

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment ____
First Middle Last

Date of Birth _______________ SS# __________________________ Relationship to Patient __________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Phone: Land-line_________________________ Cell _________________________ Work __________________________

Employer ____

Employer's Address ____
Street City State Zip Code +4

Other Parent's Name____ Date of Birth _______________
First Middle Last

Other Parent's Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Other Parent's Phone: Land-line____________________ Cell ____________________ Work _____________________

INSURANCE INFORMATION

INSURANCE PLAN NAME ________________________________ Effective Date ______________ Primary ☐ Secondary ☐

Name of Subscriber/Policyholder ____ Gender ______________
First Middle Last

Date of Birth ______________ SS# ________________________ Relationship to Patient ________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Phone: Land-line_______________________ Cell _______________________ Work ________________________

INSURANCE PLAN NAME ________________________________ Effective Date ______________ Primary ☐ Secondary ☐

Name of Subscriber/Policyholder ____ Gender ______________
First Middle Last

Date of Birth ______________ SS# ________________________ Relationship to Patient ________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Phone: Land-line_______________________ Cell _______________________ Work ________________________

INSURANCE PLAN NAME ________________________________ Effective Date ______________ Primary ☐ Secondary ☐

Name of Subscriber/Policyholder ____ Gender ______________
First Middle Last

Date of Birth ______________ SS# ________________________ Relationship to Patient ________________________

Address – **Same as Patient** ☐ ____
Street/Apt or Lot# City State Zip Code +4

Phone: Land-line_______________________ Cell _______________________ Work ________________________

For Office Use Only

Information updated in NueMD by _____________________ Date ______________

Information updated in DrFirst by ______________________ Date ______________