

**NEW PATIENT REGISTRATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: M F

SSN \_\_\_\_\_ MARITAL STATUS: Single Married Divorced Widowed

MAILING ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ (for billing purposes only)

(please circle)

Race : White Black/African American American Indian/Alaska Native Asian

Native Hawaiian/Pacific Islander Other Decline

Ethnicity : Hispanic/ Latino NOT Hispanic/Latino Decline

EMERGENCY CONTACT#1 \_\_\_\_\_ PHONE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

EMERGENCY CONTACT#2 \_\_\_\_\_ PHONE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

For notification of test results can we leave a voice mail message? YES NO initial \_\_\_\_\_

Can we leave a message with who answers the phone number given? YES NO initial \_\_\_\_\_

I give Emurgent Care permission to discuss my information with: (please circle)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Financial Medical

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Financial Medical

Primary Insurance \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_

Insurnace ID# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_

Insurnace ID# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_