# Patient Registration Form

## Patient Information

Name: _____ Preferred first name: _____

DOB: _____ ❑ Female ❑ Male SSN: _____

Primary phone: _____ Type: ❑ Home ❑ Cell ❑ Work Marital status: _____

Primary patient notification preference: ❑ Primary phone ❑ Secondary phone ❑ Mail

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

Primary language: _____ ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Primary address: _____

City: _____ State: _____ Zip: _____

Country of primary address: _____

Secondary phone: _____ Type: ❑ Home ❑ Cell ❑ Work

Personal email*: _____ Preferred method of notification: ❑ Phone ❑ Email

**Personal email is required for access to the patient portal*

Secondary address: _____

City: _____ State: _____ Zip: _____

## Additional Patient Information

Primary care physician: _____

Person financially responsible: _____ Relationship: _____

Referring physician (if different from primary care): _____

How did you hear about us? _____

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Emergency contact: _____ Emergency contact: _____

Relationship to contact: _____ Relationship to contact: _____

Contact phone: _____ Contact phone: _____

Employment status: _____

# Patient Registration Form

## Insurance Information

Primary:_____ Secondary:_____

Policy holder ID: _____ Policy holder ID:_____

Policy holder name:_____ Policy holder name: _____

Policy holder DOB: _____ Policy holder DOB: _____

Policy holder's employer: _____ Policy holder's employer: _____

Patient relationship to policy holder: _____ Patient relationship to policy holder: _____

Policy holder sex: ❑ Female ❑ Male Policy holder sex: ❑ Female ❑ Male

Copay amount: _____

Pharmacy: _____ Location: _____

Pharmacy phone: _____

## Extended Information

Do you have a visual impairment that will prevent you from reading written material from your doctor? ❑ Yes ❑ No

Do you have a hearing impairment that will complicate spoken communication with your doctor? ❑ Yes ❑ No

Have you seen a specialist since your last visit with your primary care doctor? ❑ Yes ❑ No

If yes, please indicate the name of the provider(s) below.

Provider: _____

Provider: _____

**Patient signature**:_____

Date: ____/____/____

Printed name: _____

BayCare Medical Group