A+ FAMILY MEDICINE, PC

PATIENT REGISTRATION FORM

Patient's Name: _____ Date of Birth: _____

Home Address: _____ SS#: _____

City: _____State: ___ Zip: _____ Gender: M / F

Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: (circle one) Single Married Partnered Divorced Widowed
Race: (circle one) American Indian White/Caucasian African American Asian Other_____
Language preference: _____

Responsible Party Name: _____ Date of Birth: _____

Home Address: _____ SS#: _____

City: _____ State: ____ Zip: _____ Gender: M / F

Home Phone: _____ Cell Phone: _____

Email Address: _____

Family Members (Currently covered by your insurance):

Spouse: _____DOB: _____ SS# _____

Child: _____DOB:_____

Child: _____DOB:_____

Child: _____DOB:_____

Child: _____DOB:_____

Primary Insurance:_____ Policy#_____

Ins. Co. Address: _____ Group#_____

City: _____ State:_____ Zip_____ Phone#_____

Policy Holder Name:_____ DOB:_____ SS#_____

Employer Name: _____ Work# _____

Occupation: _____Full Time / Part Time (circle one)

Secondary Insurance:_____ Policy# _____

Ins. Co. Address: _____ Group# _____

City: _____State:_____ Zip:_____ Phone# _____

Policy Holder Name:_____ DOB_____ SS# _____

Employer Name: _____ Work # _____

Occupation: _____ Full Time / Part Time (circle one)

Your Provider: (check one) □ Keider □ Huggler □ Earl

In Case of Emergency Contact:

Name: _____ Relationship to patient:_____

Home #:_____ Cell #:_____ Work #:_____

Please be prepared to present your insurance card at every visit so that we may verify the information we have on file. I hereby state that all of the above information is correct to the best of my knowledge.

□ By checking this box I acknowledge receipt of "Notice of Privacy Practices".

Patient Signature: _____ Date: _____
Parent/Guardian if under 18 yrs.