PATIENT REGISTRATION FORM

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| PATIENT | | | | | | | | | | | | | |
| NAME (First, Middle, Last) | | | | | | | | DATE OF BIRTH | | | | | BIRTH SEX  MALE  FEMALE  UNDIFFERENTIATED |
| STREET ADDRESS OR MAILING ADDRESS (PO BOX) CELL PHONE NUMBER | | | | | | | | | | | | | PRIMARY PHONE NUMBER |
| CITY STATE ZIP CODE | | | | E-MAIL (Required for Patient Portal) | | | | | | | | | WORK PHONE NUMBER |
| EMPLOYER | | | EMPLOYMENT STATUS  Full Time  Part Time  Self-Employed  Unemployed  Retired  Active Duty | | | | | | | STUDENT STATUS  Full Time  Part Time  Not Student | | | |
| PRIMARY CARE PROVIDER | | | MARITAL STATUS  Single  Married  Separated  Annulled Widowed  Divorced  Domestic Partner  Interlocutory  Life Partner  Polygamous  Unknown | | | | | | | | PREFERRED CONTACT METHOD  (Check all that apply)  🞎 Home Address(letters)  🞎 Home Phone 🞎 Cell Phone | | |
| PRIMARY LANGUAGE | SOCIAL SECURITY # | |
| RACE  American Indian/Alaskan Native  White/Caucasian  Black  Multiracial  Asian/Pacific Islander Refused/undetermined | | | | | | | ETHNICITY  Hispanic or Latino Not Hispanic or Latino  Refused or Undetermined | | | | | | |
| CURRENT GENDER  Female  Male  Undifferentiated | | SEXUAL ORIENTATION  Choose not to disclose  Straight or Heterosexual  Bisexual  Don’t Know  Lesbian, gay or homosexual  Something else, please describe | | | | | | | GENDER IDENTITY  Choose not to disclose  Additional gender category or other, please specify  Female  Female-to-Male(FTM)/Transgender Male/Trans Man  Genderqueer, neither exclusively Male nor Female  Male  Male-to-Female(MTF)/Transgender Female/Trans Woman | | | | |
| PREFERRED PRONOUN  Choose not to disclose  Decline to Answer  She, Her, Hers  He, Him, His  Ze, Hir  They, Them, Theirs Other | |
| RESPONSIBLE PARTY | | | | | | | | | | | | | |
| NAME (First, Middle, Last) | | | | | | DATE OF BIRTH | | | | | | SEX  MALE  FEMALE  UNDIFFERENTIATED | |
| ADDRESS | | | | | | TELEPHONE – HOME | | | | | | TELEPHONE - WORK | |
| RELATIONSHIP TO PATIENT  Parent Guardian Other | | EMPLOYER | | | | | | | | | | | |
| PRIMARY INSURANCE CARRIER SECONDARY INSURANCE CARRIER | | | | | | | | | | | | | |
| INSURANCE CARRIER NAME- | | | | | INSURANCE CARRIER NAME- | | | | | | | | |
| INSURANCE ID# ***See card*** GROUP # ***See card*** | | | | | INSURANCE ID # ***See card*** GROUP # ***See card*** | | | | | | | | |
| SUBSCRIBER (POLICY HOLDER)  NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | SUBSCRIBER (POLICY HOLDER)  NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| PATIENT-SUBSCRIBER RELATIONSHIP  Self Spouse Dependent Other | | | | | PATIENT-SUBSCRIBER RELATIONSHIP  Self Spouse Dependent Other | | | | | | | | |
| IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT? | | | | | | | | | | | | | |
| NAME DAYTIME TELEPHONE EVENING TELEPHONE | | | | | | | | | | | | | |
| **If you are here for an injury, is it:**  Work Related  Auto Related Neither | | | | | | | | | | | | | |

#### ALL PAYMENT DUE AT TIME OF SERVICE

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of services. I will be responsible for fees and charges according to Frederick Health Medical Group and my health plan. If I do not provide a VALID insurance card at each visit, I will be held responsible for services and asked to sign a waiver. If the account were to be referred to a collection agency, I will pay all fees and collection expenses. I understand that I may be contacted by Frederick Health Medical Group and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages, and/or an automatic dialing device (“auto dialer”), by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or

Patient Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_