Patient Registration 18 yrs +

PATIENT INFORMATION

Patient: Last Name:_____First Name:_____MI:_____

D.O.B.:_____/_____/_____Sex: M/F Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Pacific Islander / White/American Indian/Alaskan

Primary Care Provider (circle one): Karen Dettmer, MD Sophia Grant, MD Richard Tenczar, MD Michelle Henry, APRN

Patient cell phone (_____) _____

Mailing Address:_____

Home Phone: (_____)_____

Email Address: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Cell Phone / Email

Billing Statements: Home Address / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

INSURANCE

Primary Policy: ☐ Check if HUSKY/Medicaid and skip to contacts section

Policy Holder's Name: _____

Policy Holder's Birth Date:_____Policy Holder's Sex: Male / Female

Insurance Carrier: _____

ID#_____Group # _____

Secondary Policy: ☐ Check if HUSKY/Medicaid and skip to contacts section

Policy Holder's Name: _____

Policy Holder's Birth Date:_____Policy Holder's Sex: Male / Female

Insurance Carrier: _____

ID#_____Group # _____

EMERGENCY CONTACTS

Contact 1: Name:_____Date of Birth:_____/_____/ _____

Relation to Patient:_____Lives with patient? Yes / No

Home Phone: (_____)_____-_____Cell Phone: (_____)_____- _____

Work Phone: (_____)_____-_____Home Email: _____

Employer:_____Occupation:_____

Address (if different from patient)_____

___ I give permission for the office to speak with my parent/contact

____ I only give permission for the office to speak with my parent/contact on a case by case basis

____ I do not give permission for the office to speak with my parent/contact

Contact 2: Name:_____Date of Birth: _____/_____/ _____

Relation to Patient:_____Lives with patient? Yes / No

Home Phone: (_____)_____-_____Cell Phone: (_____)_____- _____

Work Phone: (_____)_____-_____Home Email: _____

Employer:_____Occupation:_____

Address (if different from patient)_____

___ I give permission for the office to speak with my parent/contact

____ I only give permission for the office to speak with my parent/contact on a case by case basis

____ I do not give permission for the office to speak with my parent/contact

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____