caring hearts
MEDICAL CLINIC

PATIENT REGISTRATION

PATIENT INFORMATION

NAME: _____ Email: _____
(First) (Middle initial) (Last)

ADDRESS: _____
(Number and street) (Apt #) (City) (State) (Zip code)

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____ AGE: _____
(Cell or home) (Cell or home)

BIRTH DATE: _____ GENDER: ☐Female ☐Male MARITAL STATUS: _____

RACE: _____ PRIMARY LANGUAGE: _____ SS #: _____

ETHNICITY: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown ☐Declined Interpreter Services needed ☐Yes ☐No

EMPLOYER / SCHOOL: _____ EMPLOYER PHONE: _____

ADDRESS: _____
(Number and street) (Apt #) (City) (State) (Zip code)

OCCUPATION: _____ BY WHOM WERE YOU REFERRED: _____

OTHER PHYSICIANS INVOLVED IN YOUR CARE: _____

IN CASE OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE#: _____ ALTERNATE PHONE#: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME _____

ID# _____ GROUP# _____

_____
POLICY OWNER NAME & RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

INSURANCE NAME _____

ID# _____ GROUP# _____

_____
POLICY OWNER NAME & RELATIONSHIP TO PATIENT

I request and authorize my physician and other physicians who may attend to me, their associates and assistants, including those employed by the Caring Hearts Medical Clinic (hereinafter referred to as CHMC), employees and supervised students to provide and perform such medical care, tests, procedures, drugs and other special services and tests ordered by my physician.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

X _____ _____
Signed Date

Rev 03/2014