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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_