Redmond Family Medicine Patient Registration Form

PATIENT INFORMATION

Name_____ Date of Birth ____/____/_____ Sex: M ☐ F ☐
First Middle Last

Other Names Used (Maiden, Nickname, Etc.): _____

Soc. Security_____-_____-_____ Preferred Language_____ Email _____

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Work Phone (_____)_____-_____

☐ it is okay to leave a voicemail ☐ it is okay to leave a voicemail ☐ it is okay to leave a voicemail

Which phone number do you prefer we attempt to contact you on first? (please circle one): Home Cell Work

Employer_____Occupation_____

Employer Address_____

Marital Status_____ **Spouse/Partner Name**_____ Spouse Date of Birth____/____/_____

Spouse Phone (_____) _____-_____ Spouse Employer_____

PAYMENT INFORMATION:

Do you have Health Insurance?: YES ☐ NO ☐ Do you have more than 1 insurance? YES ☐ NO ☐

Primary:

Insurance Company_____ Name of policy holder_____
Relationship (check one): Self☐ Spouse ☐ Parent ☐ Other ☐

Policy Holder's Date of Birth_____/_____/_____

Secondary (if applicable)**:**

Insurance Company_____ Name of policy holder_____
Self☐ Spouse ☐ Parent ☐ Other ☐

Policy Holder's Date of Birth_____/_____/_____

IN CASE OF EMERGENCY

Relative other than spouse_____Phone (_____) _____-_____
Name and Relationship

Non-relative person to contact_____ Phone (_____) _____-_____
Name and Relationship

OTHER INFORMATION

Please list any other doctors you are seeing and what they are treating you for:_____

_____

Are any of your family members our patients as well? _____

How did you hear about our clinic? _____

I, the undersigned, verify that the above information is true and accurate to the best of my knowledge. I understand that unless otherwise requested, voicemails may be left on my phone confirming appointment times and dates.

Patient Signature:_____ **Date:**_____