OUR MED
OUR FAMILY CARING FOR YOURS

PATIENT REGISTRATION FORM

Today's Date _____

Last Name _____ **First Name** _____

Preferred Name_____

Middle Name _____ **Suffix** _____ **Former Last Name** _____

Sex: (Circle One) Male Female **Date of Birth** _____/____/_____ **SSN** ____ - _____ - _____

Street Address _____

Zip Code _____ **City** _____ **State** _____

Home Phone ( ) _____ **Mobile Phone** ( ) _____

Work Phone ( ) _____ **Email** _____

Contact Preference: (Circle One) Home Phone Mobile Phone Work Phone

Language: (Circle One) Chinese English Spanish/Castilian Korean

☐ I Decline to answer this question.

Race: (Circle One) American Indian Asian Asian Indian
Black/African American European Filipino Japanese
Korean Native Hawaiian or other Pacific Islander White/Caucasian

☐ I Decline to answer this question.

Ethnicity: (Circle One) Hispanic or Latino Non Hispanic or Latino

☐ I Decline to answer this question.

Marital Status: (Circle One) Married Single Divorced Separated Widowed Partner

Guardian Information

Last Name _____ **First Name** _____

Middle Name _____ **Suffix** _____

Emergency Contact

Name _____ **Relationship to Patient** _____

Home Phone ( ) _____ **Mobile Phone** ( ) _____

Employment

Employer Name _____

Employer Phone # ( ) _____

Usual occupation _____

Guarantor Information (Name of whom statements are sent)

Patient's relationship to guarantor_____

Last Name _____ **First Name**_____

Middle Name _____ **Suffix** _____

DOB _____

☐ Check here is Mailing address is same as Patient's.

Street Mailing Address_____

Zip_____ **City**_____ **State**_____

Insurance Information

Primary Insurance Company Name _____

Contract # _____ **Group #** _____

Subscriber Name _____ **Subscriber Date of Birth** __/__/__

Patient's Relationship to Subsrcriber_____

Primary Insurance Mailing Address _____

Primary Insurance Contact Phone # (____)_____

Secondary Insurance Company Name_____

Contract # _____ **Group #** _____

Subscriber Name _____ **Subscriber Date of Birth** __/__/__

Patient's Relationship to Subsrcriber_____

Secondary Insurance Mailing Address _____

Secondary Insurance Contact Phone # (____)_____

Tertiary Insurance Company Name _____

Contract # _____ **Group #** _____

Subscriber Name _____ **Subscriber Date of Birth** __/__/__

Upon Completion, Please return all forms to front desk with a valid Driver's License and Current Insurance Cards.