HONORHEALTH

Medical Group

New Patient Registration – Demographics and Insurance

Patient: Name/First _____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Patient street address: _____

Patient address additional: _____

City: _____ State: _____ ZIP: _____-_____

Primary Phone Number: (_____) _____-_____Mobile | Home | Work

Secondary Phone Number: (_____) _____-_____Mobile | Home | Work

Email address: _____

What is your primary language? _____ Interpreter Required? Yes | No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

Religious preference: _____ ☐ I prefer to not answer.

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?
   _____Hispanic or Latino _____ Not Hispanic or Latino
   _____ I prefer to not answer.

2. How do you identify your race?
   _____ American Indian or Alaska Native _____ Black or African American
   _____ Native Hawaiian _____ Other Pacific Islander
   _____ White or Caucasian _____ Asian
   _____ I prefer to not answer

Who is your primary care physician? _____

Name of the primary care practice: _____

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: _____

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don't know

Patient Name: First_____ Middle_____ Last_____ Date of Birth: ____/_____/_____

Who would you like to list as an **emergency contact**?

Name: _____

Address: _____

_____

Relationship to you: _____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Who is the **guarantor** of your account? Who is financially responsible for any amount not paid by the insurance company? Please write "self" if you are financially responsible.

Guarantor: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Medical Insurance Company Name: _____

Member/Subscriber Identification #: _____ Group #: _____

Medical Insurance Company Address: _____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: _____

Subscriber: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Do you have any additional insurance? Yes | No
Please present all insurance cards.