XCEL
PRIMARY CARE

Patient Registration Form

Date: ____________	Primary Doctor: ____________	
First Name: ____________	Last Name: ____________	
Middle Name: ____________	Date of Birth: ____________	Gender: ☐ M ☐ F ☐ Other
Street Address: ____________ Apt: ____________ City: ____________ State: ____________ Zip Code: ____________		
Cell Phone: ____________	Home Phone: ____________	Work Phone: ____________
Email Address: ____________		
Insured: ☐ Yes ☐ No	Primary Insurance Company: ____________	Secondary Insurance Company: ____________

IN CASE OF AN EMERGENCY

Name:	Relationship to Patient:	Cell Phone:	Work Phone:
____________	____________	____________	____________