

Registration Form



University
Physician Group

Date _____

Patient Information

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Last Four Digits of SSN: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Ethnicity: Hispanic, Latino or Spanish origin Non Hispanic, Non Latino or Non Spanish origin

Race: African American/Black Caucasian/White Middle Eastern Asian Greek Hispanic Indian
 More than one race Native American Indian Native Hawaiian or other Pacific Islander

Marital Status: S M D W **Gender:** M F

Preferred Language: _____ **Interpreter Need:** Y N

Insurance Guarantor: Self Parent Other _____

Patient Employer: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Preferred Method of Communication: Home Work Cell Portal Other: _____

Would like to receive appointment reminders and promotional text messages: Yes No

E-Mail Address: _____

Legal Guardian - 1

Name: _____

Relationship: _____

Address Same as Patient

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Legal Guardian - 2

Name: _____

Relationship: _____

Address Same as Patient

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____ Relationship to Patient: _____

Do you have an **Advance Directive** or a formal document indicating who your Durable Power of Attorney is for health care decisions? Yes No

If no, would you like the physician to provide you information on Advance Health Care Directives? Yes No

Pharmacy

We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:

Local Pharmacy: _____ Phone Number: _____

Address: _____ City: _____

(street address if known or main road with closest cross street)

Mail Order Pharmacy: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

How did you hear about us? Physician Family Friend Website Advertisement Attorney

Other: _____

Registration Form

Primary Care Family Physician

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Referring Physician Is My Primary Family Physician

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Primary Insurance: _____ Group # _____ ID# _____

Subscribers Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____

SSN of Subscriber if Veteran's Insurance: _____ Subscriber Date of Birth: _____

Sex of Subscriber: Male Female Subscriber Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Group # _____ ID# _____

Subscribers Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____

SSN of Subscriber if Veteran's Insurance: _____ Subscriber Date of Birth: _____

Sex of Subscriber: Male Female Subscriber Address: _____

City: _____ State: _____ Zip: _____

Other Insurance: Vision Dental Other Medical _____

Subscribers Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____

SSN of Subscriber if Veteran's Insurance: _____ Subscriber Date of Birth: _____

If patient is being seen due to injury please complete the following:

_____ Injury at work Date: _____ From a lift twist fall bend pull reach

Claim number: _____

Name and number of case worker/adjuster: _____

_____ Auto Accident Date of Accident: _____ State of Injury: _____

Claim number: _____

Name and number of case worker/adjuster: _____

Patient Signature: _____ Date: _____

Print Name(s) of Legal Guardian: _____ Phone Number: _____

Responsible Party Signature: _____ Relationship: _____

(if patient is minor or has guardian)