FAMILY MEDICINE ASSOCIATES
OF NORTH STAFFORD

Patient Registration Form

Last Name _____ First Name _____ MI _____

AKA (Also Known As) /Previous Last Name(s) _____

Social Security#___-_____-_____ Date of Birth__/___/____ Birth Gender:_____ Gender Identity: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Legally Separated ___ Widowed ___ Life Partner

Home Address_____

_____

City _____ State _____ Zip Code _____

Home Phone (_____)_____ Cell Phone (_____)_____

Alternate Phone (_____)_____ Alternate Phone Info_____

E-Mail _____

Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Alt Phone ☐ E-Mail ☐ Text

Primary Care Physician/Pediatrician_____

If pediatric patient, please list siblings _____

_____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Pacific Islander or Native Hawaiian ☐ Multiracial ☐ Other Race- Please Print _____

Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

☐ Other/Unknown-Please Print if Other _____

Language Preference: If other than English- Please Print. _____

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication? ☐ Yes ☐ No

If yes, please check appropriate item(s): ☐ Vision ☐ Hearing

Patient's Employer _____

Address _____

City _____ State _____ Zip Code_____

Work Phone Number_____ Ext _____

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients ☐ Guarantor? ☐ Legal Guardian?

Guarantor/Legal Guardian Name_____ Social Security# _____

Patient's Relationship to Guarantor/Legal Guardian: ☐ Spouse ☐ Dependent Child ☐ Student

Date of Birth_____ ☐ Other- Please Print _____

Guarantor/Legal Guardian Home Address _____

_____

City _____ State _____ Zip Code _____

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

Guarantor/Legal Guardian Employer Name & Address _____

_____

City _____ State _____ Zip Code _____

Emergency Contact - Who to call in the event of an Emergency

1. Name _____ Relationship _____

   Cell/Hm Phone# (_____) _____ Work Phone# (_____) _____

2. Name _____ Relationship _____

   Cell/Hm Phone# (_____) _____ Work Phone# (_____) _____

Is your visit due to a job related injury or automobile accident? ☐ Yes ☐ No

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) ☐ Yes ☐ No

Does the patient have insurance? ☐ Yes ☐ No

Primary Insurance Information - *Please complete the below information.*

Plan Name _____

Policy Holder's Name _____ Gender: ☐ Male ☐ Female

Policy Holder's SSN# ___-___-___ Policy Holder's Date of Birth ___/___/___

Secondary Insurance Information - *Please complete the below information.*

Plan Name _____

Policy Holder's Name _____ Gender: ☐ Male ☐ Female

Policy Holder's SSN# ___-___-___ Policy Holder's Date of Birth ___/___/___

Patient/Guarantor Printed Name _____ Patient DOB ___/___/___

Patient/Guarantor Signature _____ Date ___/___/___