MedCare

Patient Registration

PATIENT INFORMATION

_____ _____ **Sex:** ☐ Male ☐ Female

Full legal name (First, Middle, Last, suffix) **Nickname**

_____ _____ _____ _____

Date of birth **Social security number** **Race** **Preferred language**

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Complete mailing address: _____

(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

E-mail: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date _____

Employer name: _____ **Employer phone number:** _____

Employer complete address: _____

(Street, city, state, zip code, county)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ☐ Same as patient

_____ _____ _____

Full legal name (First, Middle, Last, suffix) **Date of Birth** **Social security number**

Relation to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____ **Sex:** ☐ Male ☐ Female

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Complete mailing address-if different from patient: _____

(Street, city, state, zip code, county)

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer phone number:** _____

Employer complete address: _____

(Street, city, state, zip code, county)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Complete mailing address-if different from patient: _____

(Street, city, state, zip code, county)

INSURANCE INFORMATION ☐ Self-pay (no insurance)

Primary insurance: _____ **Patient relation to subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary insurance: _____ **Patient relation to subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer size:** ☐ 0-19 employees ☐ 20-99 ☐ 100+

Employer complete address: _____

(Street, city, state, zip code, county)

Primary care physician:	**Is this visit accident related?** ☐ Yes ☐ No	**Do you want anyone to know you are here?** ☐ Yes ☐ No Name: _____ Telephone #: _____

Not a part of the Legal Medical Record