New Patient Registration

MEDcare GET BETTER. FASTER.

PATIENT INFORMATION

Last Name ________ First Name ________ Middle Initial ________ DOB MM/DD/YYYY ____/____/________

Address/Apt/Suite ________ City ________ State ________ Zip Code ________

Home Phone (______) ______-________ Mobile Phone (______) ______-________ Email ________@________

DEMOGRAPHICS

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Gender

☐ Male ☐ Female
☐ Other________________

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Preferred Language

____

CARE TEAM

Primary Care Physician (PCP) ____

Emergency Contact

Last Name ________ First Name ________ Relationship ________ Preferred Phone (______) ______-________

Responsible Party/Guarantor

Last Name ________ First Name ________ Relationship ________ DOB MM/DD/YYYY ____/____/______ Preferred Phone (_____) _____-_______

Address/Apt/Suite ________ City ________ State ________ Zip Code ________

Visit Information

Reason for Visit ________________________ **Preferred Pharmacy(Incl. Location)**________________________

Payment Source ☐ Uninsured/Self-Pay ☐ Primary Insurance ☐ Secondary Insurance ☐ Employer: ______________

Primary Insurance Company: ______________________ ☐ Insurance Card Avail ☐ Not Avail (Fill out Information)

Insurance Plan ________ Policy #/Subscriber ID ________ Group # ________

Insurer ☐ Same as Patient ☐ Same as Guarantor ☐ Other (Fill out Information)

Last Name ________ First Name ________ Relationship ________ DOB MM/DD/YYYY ____/____/________

How Did You Hear About Us? ____

Revised: 06/20/18