Community Care Physicians Adult/Specialist Patient Registration Form

Date: _____ **Patient ID#:** _____
(for office use only)

PATIENT INFORMATION

Social Security Number _____/_____/_____ (Providing your SSN is optional. However, for patients with certain insurances this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Legal Name: _____ Preferred Name: _____

Street Address: _____
Mailing Address (if different, i.e. PO Box): _____

City: _____ State: _____ Zip: _____ Home Phone #: ( ) _____

Work #: ( ) _____ Cell #: ( ) _____ Preferred daytime phone: □ Home □Work □ Cell

Date of Birth: _____/_____/_____ Gender: □ Male □ Female □ Other _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

E-mail Address: _____ **Would you like to participate in the patient portal?**
□ Yes □ No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
□ American Indian/Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ Black/African American
□ White
□ Other

Ethnicity: Select One
□ Hispanic/Latino
□ Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Emergency Contact DOB: _____/_____/_____

Emergency Phone: ( ) _____ Relationship to Patient: _____

Primary Care Physician: _____ Referring Physician: _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

□ E-Mail (when available) □ Text □ Office may leave a message at home

Please Complete Page 2

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MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $_____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

_____ _____/_____/_____

Signature of Patient / Guardian Date