PATIENT REGISTRATION (Please Print Clearly) ***NEW Patient_____UPDATE Demographics_____***

Today's Date_____

Patient Name_____

Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Birth date_____ Age_____ Sex: M F Trans Marital Status: M P S W D

Patient Social Security #_____Employer_____

Spouse/Partner/ or Parent-Guardian Name_____

Spouse/Partner/Parent-Guardian Phone_____

Email (if no email state NONE): _____

Please circle *one from each list*

Race:	***Ethnicity***	***Primary Language Spoken***
American Indian or Alaska Native	Hispanic or Latino	English
Asian	Not Hispanic or Latino	Spanish
Black or African American	Rather not Report	French
Hispanic		Mandarin
White		Other
Other Race		
Rather not Report		

Emergency Contact_____Relation to you_____

Emergency Contact Phone_____

Ok to talk to emergency contact regarding personal medical information as covered by HIPAA_____Yes _____No

Preferred Pharmacy_____City_____

Financially Responsible Party Self (if 18 yrs or over) **OR** Other

Name (if other than self)_____

Address:_____

City:_____State:_____Zip:_____

Phone: _____

Birth date of Responsible Party_____ Social Security #_____

PRIMARY *Medical Insurance*_____

*Insured Party : Self Spouse/Partner Parent Other Insured Party Date of Birth*_____

*Name (if other than self)*_____

SECONDARY *Medical Insurance* _____

*Insured Party : Self Spouse/Partner Parent Other Insured Party Date of Birth*_____

*Name (if other than self)*_____

Is it okay to leave a message on **your** listed phone(s) or email regarding your appointment reminder and/or other medical care?_____Yes _____No

Is it okay to leave a message the listed phone for your **spouse/partner/parent-guardian** regarding your appointment reminder and/or other medical care?_____Yes No_____

How or by whom were you referred to West Bend Family Medicine?_____