Reid Health
Physician Associates

Entered By:____________
Practice:____________

PATIENT REGISTRATION FORM

Name:______________________________ Maiden Name:__________
First Middle Initial Last — or other name used

PATIENT INFORMATION

Race: „ American Indian/Alaska Native „ Black/African American „ White ☐ Hispanic/Latino „ Refused/Unknown „ Native Hawaiian/Other Pacific Islander „ Asian

Ethnicity: „ Not Hispanic/Latino „ Hispanic/Latino „ Unknown/Refused

Language: „ English „ Spanish „ French „ Mandarin „ Japanese „ Hindi „ Other

SS #__________ Birth Date__________ Marital Status: S M D W Sex: M F

Address__________ Street City State Zip

List your contact numbers and ð your preferred contact method below:

„ Home__________ „ Cell__________ „ Portal__________

Email Address__________

Employer Name__________ Status: Full-Time Part-Time Retired None

Employer Address__________ Street City State Zip

Student Status if applicable: Full-Time Part-Time Name of College/Univ/School__________

Primary Care Physician__________ Referred by__________

Birth Mother's Full Name__________ First Middle Initial Last Maiden

INFORMATION FOR MINORS

Note: If the patient is a minor, please complete this section regarding financial responsibility.

Guarantor Name__________

Address (if different from patient's)__________ Street City State Zip

SUPPORT ROLE CONTACT INFO

Name__________ Relationship__________ Phone__________
Please ð all that apply: „ Emergency Contact „ Caregiver „ Next of Kin
Address__________ Street City State Zip

Name__________ Relationship__________ Phone__________
Please ð all that apply: „ Emergency Contact „ Caregiver „ Next of Kin
Address__________ Street City State Zip

INSURANCE INFORMATION

PRIMARY CO__________ Policy/ID #__________ Group #__________
Insured Party: Self Spouse Parent Insured Name (if not the patient)__________
Birth date__________ SS #__________ Employer__________ Employer Phone__________
Employer Address__________ Street City State Zip

SECOND CO__________ Policy/ID #__________ Group #__________
Insured Party: Self Spouse Parent Insured Name (if not the patient)__________
Birth Date__________ SS #__________ Employer__________ Employer Phone__________
Employer Address__________ Street City State Zip

THIRD CO__________ Policy/ID #__________ Group #__________
Insured Party: Self Spouse Parent Insured Name (if not the patient)__________
Birth Date__________ SS #__________ Employer__________ Employer Phone__________
Employer Address__________ Street City State Zip

The insurance information I have provided on this form is accurate and complete. If I have not listed any insurance information, then I understand that I may be responsible for payment in full as described in the RPA Patient Financial Policy.

Patient or responsible party signature:__________ Date:__________