Registration Form - EPC

Today's Date:	PCP:	
PATIENT INFORMATION		
Patient's Last Name:	First:	Middle:
If patient is a minor, Parent/Guardian Name:		
Date of Birth:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Email Address:	Preferred Pharmacy:	
Social Security Number:	Driver's License No. & State:	
Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Preferred Language:
Employer:	Employer Address:	Employer Phone:
Emergency Contact:	Relationship to Patient:	Phone Number:
INSURANCE INFORMATION		
Subscriber Name:	Subscriber DOB:	
Policy Number:	Group Number:	Relationship to Policy Holder:
GUARANTOR INFORMATION (if patient is a minor)		
Person Responsible for Account:	Birth Date:	Relationship to Patient:

DCH Health System®

Clinic Registration EPC

AM-REG-EPC