

## Registration Form - FMC Medical Clinic - Fayette (FMC)

Today's Date:		PCP:	
<b>PATIENT INFORMATION</b>			
Patient's Last Name:		First:	Middle:
If patient is a minor, Parent/Guardian Name:			
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> 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: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Preferred Language:	
Employer:	Employer Address:		Employer Phone:
Emergency Contact:		Relationship to Patient:	Phone Number:
<b>INSURANCE INFORMATION</b>			
Subscriber Name:		Subscriber DOB:	
Policy Number:	Group Number:	Relationship to Policy Holder:	
<b>GUARANTOR INFORMATION (if patient is a minor)</b>			
Person Responsible for Account:		Birth Date:	Relationship to Patient:



**Clinic Registration  
FMC**

