FMC Medical Clinic Millport

Patient Registration Form

First Name:____Last Name_____________________________Middle:_____________

Address: ____

City:______________________________________St:__________________________________Zip: ______________________

Phone: (Home) ___________________________ (Cell)____________________________(Work) _________________________

Sex: _______ Marital Status:_________Birthdate:____/___ /___ Email Address: _______________________________________

Employed: Y / N Employer:______ ______________ Employer Address:________________________ Phone No.: ____________

Social Security No.:________________Driver's License No. & State : _________

Race: ________________ Hispanic/Non-Hispanic:_____________ Gender _____________

Preferred language:______________________ If interpreter, name of interpreter: _______________________________________

If patient is a minor, Parent / Guardian Name:_________________________

Preferred Pharmacy:______________________ Phone #:_____________________

Reason for Today's Appointment:____

Emergency Contact Person to notify in case of emergency: _____________________ Relationship to patient: ____________________

Emergency Contact Mailing Address:____

Phone Number:______________________________ Alt Phone Number:____________ _______________

Insurance Information

Person responsible for account:____Relationship to patient: _________________

Address: ____

City:____St:__________________________________Zip: ______________________

Phone: (Home) _____________________________ (Cell)____________________________(Work) _________________________

Insurance company (primary): ____

Name of policy holder:__________________ Policy Holder SSN:______________ Birthdate of policy holder: _______________

Employer of policy holder:____Contract/Group: ________________________

Relationship of patient to policy holder: ____

Insurance company (secondary): ____

Name of policy holder:__________________ Policy Holder SSN:______________ Birthdate of policy holder: _______________

Employer of policy holder:____Contract/Group: ________________________

Relationship of patient to policy holder: ____