

GEORGETOWN MEDICAL CLINIC

Patient Registration Form

New Patient Established Patient Dr. _____ Appt. Time: _____
 Date: _____

PATIENT INFORMATION

Patient Name: _____
Last First M.Initial

Address: _____
Street City State Zip

Home #: _____ **Work #:** _____ **Cell#:** _____

Date of Birth: _____ Female Male **Marital Status:** _____

SSN: _____ **Employer:** _____ **Student:** Yes No

Language: _____ **Race:** _____ **Ethnicity:** _____

Pharmacy Name: _____ **Phone#:** _____

Location: _____

Emergency Contact - Name: _____ **Relationship:** _____

Address: _____

Home#: _____ **Work#:** _____

Patient E-mail address: _____

INSURED/ RESPONSIBLE PARTY

Responsible Party

_____ Last First M. Initial

Address: _____
Street City State Zip

Date of Birth: _____ **Sex:** _____ **Telephone#:** _____

Relationship to Patient: ___ Parent/Guardian ___ Spouse ___ Other _____

Insurance Company Name: _____

Address: _____

Telephone#: _____ **Policy/Group#:** _____

Is this visit related to an on the job injury or auto accident? ___ Yes ___ No

We would appreciate knowing how you learned about our practice.

(Please check all that apply):

- | | |
|---|-----|
| <input type="checkbox"/> Received Card in Mail | MLR |
| <input type="checkbox"/> Newspaper Ad | NP |
| <input type="checkbox"/> Yellow Pages listing | YP |
| <input type="checkbox"/> Internet Search | NET |
| <input type="checkbox"/> Radio Commercial | RAD |
| <input type="checkbox"/> Television Commercial | TV |
| <input type="checkbox"/> Healthfair or Community Event | HF |
| <input type="checkbox"/> Former Patient | FP |
| <input type="checkbox"/> Insurance Plan Provider List | INS |
| <input type="checkbox"/> Friend/Relative's Recommendation | FR |
| <input type="checkbox"/> Other _____ | O |

*Thank you for choosing
Georgetown Medical Clinic*

