PROCARE INTERNAL MEDICINE ASSOCIATES

Patient Registration

DATE:

PATIENT INFORMATION		
Last, First, MI:		
Date of Birth: / /		Male / Female (circle one)
SSN:		Marital Status: S / M / W / D / SEP
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Employer address:		City/State/Zip:
Email Address:		Race: White / Hispanic / Black / Asian
Primary Care Physician:		Ethnicity: Hispanic / Not Hispanic
Pharmacy Name / Number:		Preferred Language:
How were you referred to our office? (please circle one): Yellow pages / Phone Book / Friend / Insurance / Employer / Other		
PRIMARY INSURANCE		
Primary Insurance Company:		Subscriber ID#:
Last, First, MI:		Group #:
Date of Birth: / /		Male / Female (circle one)
SSN:		
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Relationship to Patient:		Email Address:
SECONDARY INSURANCE		
Primary Insurance Company:		Subscriber ID#:
Last, First, MI:		Group #:
Date of Birth: / /		Male / Female (circle one)
SSN:		
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Relationship to Patient:		Email Address:
EMERGENCY CONTACT PERSON		
Last, First, MI:		Email address:
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone ( )