West Atlanta Primary care

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full legal name (First, Middle,Last, Suffix). **Sex** ☐ Male ☐ Female

Date of birth **Social Security** **Race** **Preferred language**

Ethnicity ☐ Hispanic ☐ Non-Hispanic **Marital Status** ☐ Married ☐ Separated ☐ Widowed ☐ Life partner

Mailing Address:
(Street, City, Zip code, County)

Contact: Cell: Home: Appt Reminder ☐ Call ☐ Text

Email:

Employer: **Occupation:**
(Name and Contact)

(Address)

SPOUSE OR GUARANTOR INFORMATION ☐ Same as Patient

Full legal name (First, Middle,Last, Suffix). **Date of birth.** **Social Security**

Relation to Patient ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other **Sex** ☐ Male ☐ Female

Contact: Cell: Home:

Mailing Address (if different from patient):
(Street, City, Zip code, County)

EMERGENCY CONTACT INFORMATION

Name: **Contact:**
(First, Last) Cell Home

Relation to Patient: ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other

Mailing Address:
(Street, City, Zip code, County)

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INSURANCE INFORMATION

Primary insurance: _____

Policy# : _____ **Member ID#:** _____ **Effective date:** _____

Secondary Insurance: _____

Policy# : _____ **Member ID#:** _____ **Effective date:** _____

If you are covered under the policy of a Spouse, Partner, Parent, or Legal Guardian, please provide the following information:

Insured Name: _____
(First, Middle, Last)

Insured Social Security Number: _____ **Insured Date of Birth:** _____

Insured Address _____
(If different from patient)

Insured Contact: Cell _____ **Home:** _____

Employer Name: _____ **Cell:** _____ **Office:** _____

Employer Address: _____

Employment Status: ☐ Full-time ☐ Part -time ☐ Self-employed ☐ Not employed ☐ Retirement date _____

PHARMACY INFORMATION

Preferred Pharmacy :

Name: _____ **Phone**: _____

Address: _____

Signature: _____ **Date**: _____