GRIFFIN FACULTY PHYSICIANS

Patient Registration Form

Last Name: _____

First Name: _____ MI:__

DOB:____/____/_____ Gender(circle): M F

SSN: _____-___-_____

Address: _____

Address (cont): _____

ZIP:_____

City: _____

State:_____

Occupation:_____

Employer: _____

How did you hear about us? _____

Home Phone: _____-_____-_____

Cell Phone: _____-_____-_____

Can we send automated reminders via Text/Cell?
YES NO

Contact Preference (circle):
Home Work Mobile Mail Portal

Email: _____

Marital Status (circle):
Married Single Divorced Separated Widowed

Preferred Language: _____

Race: _____

Ethnicity: _____

If Hispanic/Latino Origin, please specify origin:
_____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____-_____-_____

Mobile Phone: _____-_____-_____

ADDITIONAL INFORMATION

Preferred Pharmacy:_____

Preferred Lab: _____

Preferred Imaging Facility: _____

Primary Care Provider:_____

Referring Provider: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Tertiary Insurance: _____ ID:_____ Group Number: _____