

Community Care Physicians, P.C. Adult/Specialist Patient Registration Form

Date: _____

Patient ID#: _____
(for office use only)

PATIENT INFORMATION

Social Security Number _____ / _____ / _____ (Providing your SSN is optional. However, for patients with certain insurances this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ FIRST NAME: _____ MI: _____

Legal Name: _____ Preferred Name: _____

Street Address: _____

Mailing Address (if different, i.e. PO Box): _____

City: _____ State: _____ Zip: _____ Home Phone #: () _____

Work #: () _____ Cell #: () _____ Preferred daytime phone: Home Work Cell

Date of Birth: _____ / _____ / _____ Gender: Male Female Other _____

Marital Status: Single Married Separated Divorced Widowed

E-mail Address: _____

Would you like to participate in the patient portal?

Yes No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
 American Indian/Alaska Native
 Asian
 Native Hawaiian or other Pacific Islander
 Black/African American
 White
 Other

Ethnicity: Select One
 Hispanic/Latino
 Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Emergency Contact DOB: _____ / _____ / _____

Emergency Phone: () _____ Relationship to Patient: _____

Primary Care Physician: _____ Referring Physician: _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

E-Mail (when available) Text Office may leave a message at home

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MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: Self Spouse Child Other _____

Co-pay: \$ _____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___ Relationship to Subscriber: Self Spouse Child Other _____

Co-pay: \$ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

Signature of Patient / Guardian

_____/_____/_____
Date