ACCESS MEDICAL CENTER PATIENT REGISTRATION

Patient Information

Patient Full Name:

☐ New Patient ☐ Existing Patient

Reason for Visit:

Date of Birth: Gender: ☐ Male ☐ Female

Social Security #: Ethnicity/Race:

Local Address: Apt #:

City: State: Zip:

Primary Phone #: ☐ Home ☐ Cell ☐ Work

Secondary Phone # : ☐ Home ☐ Cell ☐ Work

Email Address: By providing your email address, you consent to our Email Privacy Policy

How did you hear about us?

☐ Location ☐ Customer Service ☐ Email ☐ Facility Signage
☐ Family/Friend/Word of Mouth ☐ Internet/Online Search ☐ Print Advertising
☐ Radio ☐ Phone Book/Yellow Pages
☐ School/Daycare: ____________________ ☐ Employer: ____________________
☐ Community Event: __________________ ☐ Hotel: _______________________
☐ Physician Referral: __________________ ☐ Pharmacy: ____________________
☐ Apartment Complex: ________________ ☐ Insurance: ____________________

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Full Name:

Permanent Address (other than local):

City: State: Zip:

Primary Care Physician:

Employer:

Thank you for choosing Access Medical Center. Your satisfaction is important to us! Please leave your email address in the space provided and we will send you a survey about your visit today.

Insurance Subscriber Information

Complete Only if NOT the Patient

Insured Subscriber Full Name:

Subscriber's Date of Birth:

Subscriber's Social Security #:

Subscriber's Relationship to Patient:

Subscriber's Permanent Address: Apt #:

City: State: Zip:

Subscriber's Primary Phone #: ☐ Home ☐ Cell ☐ Work

Subscriber's Secondary Phone #: ☐ Home ☐ Cell ☐ Work

Subscriber's Employer:

Complete Insurance Details

Insurance Company:

Type: ☐ HMO / PPO ☐ Medicare ☐ Medicaid/AHCCCS ☐ Tricare ☐ Other

ID / Policy #: Group #:

Copay/Coins/Ded Amount: Effective Date:

Secondary Insurance? ☐ Yes ☐ No Name:

Parent/Legal Guardian of Minor or Incapacitated Adult Only

Full Name: Date of Birth:

Relationship: Contact #:

Signature

Patient's Name: Date:

Signature:

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