Patient Registration Form

Name: _____ DOB: ___/___/_____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____Language: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Prefer Not to Answer

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Referred By: _____

Emergency Contact: _____ Phone: (_____) _____-_____ Relationship: _____

Local Pharmacy: _____ Phone Number: _____

Race:
□ Asian
□ Black/African American
□ Caribbean
□ Hispanic
□ Native Hawaiian/ Other Pacific Islander
□ White
□ Other
□ Prefer Not to Answer

Ethnicity:
□ Hispanic / Latino
□ Non-Hispanic
□ Prefer Not to Answer

Do you have a: Living Will, Advance Directives, DNR, Power of attorney or none? Please circle.

I authorize PrimeNet Medical Group Inc. to leave messages regarding my treatment, including lab or imaging test results, names of medications, information pertaining to my treatment and office updates by the following method:

□ Home answering machine □ Cell phone/Voicemail □ Text □ E-mail: _____

PrimeNet Medical Group Inc. complies with HIPAA and wants to exchange text messages with you.
SMS Opt-in □ Yes □ No

I will ensure all information is up to date at every visit.

_____ _____ ____/____/_____
Patient Name **Signature** **Date**