advocare

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI _____

Other Name: _____

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

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # (DL#) _____ State(ST) _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian ☐ Asian ☐ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Unknown ☐ Patient Refused

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ Other ☐ Patient Refused

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F

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

Employer: _____ Cell Phone: (_____) _____

Address: _____ City, State, Zip: _____

Work Phone: (_____) _____

Driver's License # (DL#) _____ State(ST) _____ Guarantor E-Mail: _____

Emerg. Cont.: _____ Patient's Relationship to Emerg. Cont.: _____

Home Phone: (_____) _____

Alt Phone: (_____) _____ Cell Phone: (_____) _____

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing

☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other