Primary Care of Cedar Hill
PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: ____________________ How did you hear about us?:__________________________________

Name: (Last, First, Middle)____

Name you prefer to go by:_______________________________ Birth/Maiden Name:___________________________

Date of Birth: ___________________ Age: _______ Social Security #: ____________________________

Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ Declined ☐ Amer. Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other

Ethnic Group: ☐ Declined ☐ American ☐ Hispanic ☐ African American ☐ Asian ☐ Other

Language: ☐ English ☐ Other

Address: ____ City:__________________________________

State: __________ Zip: _______________ Home Phone: ______________________ Work: ______________________

Cell Phone: _________________________ Email Address: ____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Driver's License Number: ____ Driver's License State: _______________

Employer Name and Address: _____________________________________ Occupation: ________________________

RESPONSIBLE PARTY INFORMATION – Note if you are over the age of 18 yrs. You are responsible for yourself.

Name of Responsible Person: ____ Date of Birth:____________________

Relationship to patient: ☐ Self ☐ Child ☐ Spouse ☐ Other

Address: ____ City:___________________________________

State: ____________ Zip: ______________ Home Phone: ____________________ Cell Phone: ___________________

Employer Name and Address: ______________________________________ Occupation: ________________________

Continuation: PATIENT INFORMATION

Are you an Organ Donor: ☐ Yes ☐ No Do you have a Living Will? : ☐ Yes ☐ No ☐ Unknown

Do you have an Advanced Directive? ☐ Yes ☐ No ☐ Unknown

Would you like to receive additional information about Advanced Directives? ☐ Yes ☐ No

What is your most Commonly Used Pharmacy: ______________________________ Where? ______________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name**:** ______________________________________ Relationship to patient: __________________

Home: ________________________ Cell: ____________________________ Work: _________________________

(PRIMARY) INSURANCE INFORMATION

Name of Insurance: ______________________________ ID #_________________________ Group #_______________

Name of Primary Policy Holder:_______________________________________ Date of Birth: ____________________

Relationship to the Patient: _______________________________

(SECONDARY) INSURANCE INFORMATION

Name of Insurance: ______________________________ ID #_________________________ Group #_______________

Name of Primary Policy Holder:_______________________________________ Date of Birth: ____________________

Relationship to the Patient: _______________________________

____ ____________________________________

Signature Date

____ ____________________________________

Parent (if minor) Date