



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