



MedEX Family Health Clinic

PATIENT REGISTRATION

Patient Information			
Patient Name: (Last, First, Middle Initial)		Gender:	Date of Birth:
			Social Security #:
Mailing Address: (Street / Apt. / PO Box)		City	State
			Zip Code
Home Phone:	Work Phone:	Cell Phone:	Email:
Employer:	Occupation:	Emergency Contact Name:	
Marital Status:			Emergency Contact Phone:
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Partnered x _____ years			
Who completed this form?			Emergency Contact Relationship:
<input type="radio"/> Patient <input type="radio"/> Family Member (<i>Parent, sibling etc.</i>) _____ <input type="radio"/> Partner <input type="radio"/> Guardian			
How would you like to be contacted?		How did you hear about us?	
<input type="radio"/> Home Phone <input type="radio"/> Cell Phone <input type="radio"/> Work Phone <input type="radio"/> Email <input type="radio"/> Voicemail			
Insurance Information			
Primary Insurance:		Secondary Insurance:	
ID#:	Group#:	ID#:	Group#:
Name of person responsible for the account:	Relationship:	Date of Birth:	Social Security Number:
Health Provider Information			
Name of primary care physician or medical provider:		Date last seen:	Phone number:
Address:			Fax number:
Current Medications			
Medication name, dosage, and reason for taking:		Medication name, dosage and reason for taking:	
Medication name, dosage and reason for taking:		Medication name, dosage and reason for taking:	
Medication name, dosage and reason for taking:		Medication name, dosage, and reason for taking:	