MINDEN
Physician Practices

# PATIENT REGISTRATION FORM

Patient Legal Name: _____ Marital Status: _____

Birthdate: _____ Social Security #: _____-_____-_____ May we text you? □ Yes □ No

Street or Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address (Required for portal access) _____

May we email you educational information? □ Yes □ No

Occupation: _____ Employer: _____ Employer Phone #: _____

Race: _____ Ethnicity: _____ Language (if other than English): _____

Pharmacy: _____ Pharmacy City: _____

Referred by: □ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □ Yellow Pages □ Other: _____

Family Doctor Name: _____ Family Doctor Phone #: _____

Date of last visit with family doctor: _____

## RESPONSIBLE PARTY INFORMATION

Are you responsible for the bill? □ Yes □ No □ Check here if person responsible for bill is same as patient

If not: Name of Responsible Person: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Employer: _____

Insurance Policyholder Name: _____ Birthdate _____

## EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone Number: _____

Next of Kin: _____ Relationship: _____ Phone Number: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient|Guardian Signature: _____ Date|Time:_____