MY MEDICAL CLINIC
PATIENT REGISTRATION

Patient Information:

Last Name: _____ First Name: _____ DOB: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell Phone: _____ Work Phone: _____

Preferred Method of Contact (please check one): ❑ Home ❑ Cell Phone ❑ Work Phone

Sex: _____ Marital Status: _____ Email Address: _____

Ok to contact through Email / Text ❑ Yes ❑ No

Race / Ethnicity (Select one or more)

___ American Indian or Alaska Native
___ Asian
___ Native Hawaiian or other Pacific Islander
___ Black, or African American, not Hispanic origin
___ White, not of Hispanic Origin

Are you Hispanic or Latino ❑ Yes ❑ No **Preferred Language**:_____

Preferred Pharmacy / Location / Phone: _____

May we leave a message on your home answering machine? ❑ Yes ❑ No
May we leave a message for you at work to call us? ❑ Yes ❑ No
May we discuss your medical condition with another person? ❑ Yes ❑ No

If yes, whom _____ Relationship: _____ Phone # _____

How did you hear about our practice? ❑ Insurance Plan ❑ Advertisement ❑ Family ❑ Friend ❑ Internet

RESPONSIBLE PARTY INFORMATION (if patient under 18)

Last Name: _____ First Name: _____ DOB:_____

Relationship to Patient: _____ Marital Status: _____ Sex: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Plan:_____ Member ID #_____ Group # _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

Policy holder address (if different from patient): _____

Secondary Insurance Plan:_____ Member ID #_____ Group # _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

Policy holder address (if different from patient):_____

I acknowledge that I have been provided with a copy of Privacy Practices from My Medical Clinic.

_____ _____

Signature of Patient (or Legal Representative) **Date**