Legacy Family Medicine, P.C.

ADULT REGISTRATION

PATIENT INFORMATION

PATIENT NAME (Last) (First) (Middle) ❑ Male ❑ Female

ADDRESS CITY STATE ZIP CODE BIRTH DATE | | – | | – | | | |

TELEPHONE ( ) SS# | | | – | | – | | | | STATUS: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Domestic Partnership/Civil Union RACE: ❑ Asian ❑ Multi-Racial ❑ African American/Black ❑ Caucasian/White ❑ Other ❑ Decline to Answer

CELL PHONE E-MAIL ADDRESS ETHNICITY: ❑ Hispanic/Latino ❑ Non-Hispanic /Latino ❑ Decline to Answer ❑ Unknown

EMPLOYER OCCUPATION HOW LONG EMPLOYED EMPLOYER TELEPHONE ( )

EMPLOYER ADDRESS CITY STATE ZIP CODE

PRIMARY CARE PHYSICIAN REFERRED OR RECOMMENDED BY

SPOUSE /LEGAL GUARDIAN INFORMATION

NAME (Last) (First) (Middle) RELATIONSHIP

TELEPHONE ( ) SS# | | | – | | – | | | | BIRTH DATE | | – | | – | | | |

ADDRESS CITY STATE ZIP CODE

EMPLOYER OCCUPATION HOW LONG EMPLOYED EMPLOYER TELEPHONE ( )

EMPLOYER ADDRESS CITY STATE ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE SUBSCRIBER BIRTH DATE

ADDRESS CITY STATE ZIP CODE

POLICY # GROUP # EMPLOYEE ID#/SS#/MISC GROUP NAME

INSURANCE COMPANY TELEPHONE ( ) PRE-CERTIFICATION TELEPHONE ( )

SECONDARY INSURANCE SUBSCRIBER BIRTH DATE

ADDRESS CITY STATE ZIP CODE

POLICY # GROUP # EMPLOYEE ID#/SS#/MISC GROUP NAME

INSURANCE COMPANY TELEPHONE ( ) PRE-CERTIFICATION TELEPHONE ( )

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME RELATIONSHIP

ADDRESS CITY STATE ZIP CODE

WORK TELEPHONE ( ) HOME TELEPHONE ( )

EMERGENCY CONTACT RELATIONSHIP TELEPHONE ( )

UPDATES

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

DATE SIGNATURE DATE SIGNATURE