PATIENT REGISTRATION FORM
Integro Family Health Center, P.C.

☐ New Patient ☐ Change of Patient Information Date: ____________________________

PATIENT INFORMATION

First Name	MI	Last
Street Address:		Apt:
City:	ST	Zip
Home Phone:		
Cell Phone:		
Date of Birth:	Social Security Number:	
Sex: MALE FEMALE	Marital Status:	
Email Address:		
May we send you emails regarding practice information, promotions, or updates?	YES	NO
Employer Name:		
Employer Phone:		
Emergency Contact Name:	Relationship to Patient::	
Emergency Contact Phone #:		

RESPONSIBLE PARTY INFORMATION (if other than self)

First Name	MI	Last
Street Address:		Apt:
City:	ST	Zip
Home Phone:		
Relationship to Patient:		

How did you hear about Integro Family Health?

☐ Friend/Family By Whom?________________

☐ Dr. Referral By Whom?________________

☐ Insurance Directed

☐ Yellow Pages

☐ Internet Which Website?___________

☐ Other: Please Specify ____________________

PRIMARY INSURANCE

Primary Insurance Co:		
Claim Address:		
City:	ST	Zip:
Insurance Co Phone:		
Policy/Identification Number:	Group #:	
Subscriber Name:	Relationship to Patient:	
Subscriber Date of Birth:	Subscriber Social Security Number:	
Subscriber Employer:		
Subscriber Employer Phone Number:		

SECONDARY INSURANCE

Primary Insurance Co:		
Claim Address:		
City:	ST	Zip:
Insurance Co Phone:		
Policy/Identification Number:	Group #:	
Subscriber Name:	Relationship to Patient:	
Subscriber Date of Birth:	Subscriber Social Security Number:	
Subscriber Employer:		
Subscriber Employer Phone Number:		

I verify that the above information is true and accurate to the best of my knowledge.

SIGNATURE OF PATIENT:

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SIGNATURE OF GUARANTOR IF A MINOR:

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