

# Patient Registration Form

Date: \_\_\_\_\_

Location: \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_ Male/Female  
Last First M

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_ Drivers License \_\_\_\_\_ Primary Language \_\_\_\_\_  
(Required)

Address: \_\_\_\_\_  
Street Name City State Zip County

Phones: (Home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Fax: \_\_\_\_\_ Pager: \_\_\_\_\_ Email Address: \_\_\_\_\_

**If Patient is under 18 years of age:**

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ (Relationship) \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_ Work #: \_\_\_\_\_

**Insurance Information on Policy Holder**

InsuranceName \_\_\_\_\_ ID# \_\_\_\_\_ GroupNumber \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ (Relationship) \_\_\_\_\_

Policy Holders D.O.B: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**General Medical Information: (please answer the following):**

Drug Allergies: \_\_\_\_\_ Hospitalizations: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Past and present medical problems that require medical treatment: \_\_\_\_\_

**Family History:** (Includes parents, grandparents, brothers, and sisters) check all that apply.

Heart attack  High blood pressure  Cancer  Diabetes  Stroke  Other \_\_\_\_\_

**Social History:**

Do you smoke? Yes/ No Have you ever smoked? Yes /No If yes, list packs per day \_\_\_\_\_ and year's smoked \_\_\_\_\_

Do you drink alcohol? Yes/ No If yes, How much? \_\_\_\_\_ How often? \_\_\_\_\_ daily \_\_\_\_\_ socially \_\_\_\_\_ special occasions

**Is this a work related injury? Y or N Is this an auto accident? Y or N**

**How did you hear about PMC Urgent Care?** \_\_\_\_\_