College Park Family Care Center

Compassionate, quality care.

Today's Date: _____

Primary Doctor: _____

PATIENT REGISTRATION FORM

	PATIENT	GUARANTOR (person who signed Financial Responsibility, must be at least 18yrs old, if different from pt) Pt Relationship ☐ Child ☐ Spouse ☐ Other
Last Name		
First Name, Middle		
Address, Apt #		
City, State, Zip		
Home Phone		
Mobile Phone		
Email Address		
Employer / School		
Work Phone	EXT.	EXT.
Work Address		
SSN		
Date of Birth		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow(ed) ☐ Other	
Race (choose one)	☐ Amer Indian/AK Native ☐ Asian ☐ Black/Afri-American ☐ Native HI-Othr Pacific Isl ☐ White/Cauc ☐ Other/Declined	
Ethnicity (choose one)	☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Declined	
Preferred Language	☐ English ☐ Spanish ☐ Other; Specify:	

	EMERGENCY CONTACT #1	EMERGENCY CONTACT #2
Name		
Home Phone		
Employer / Mobile Phone		
Relationship		

	PRIMARY INSURANCE	SECONDARY INSURANCE
Complete if Card Present	Effective Date (mm/dd/yy):	Effective Date (mm/dd/yy):
Insurance Company Name		
Policy Owner Name		
Policy Owner Date of Birth		
Relationship to Patient		
Complete if Card not Present	Effective Date (mm/dd/yy):	Effective Date (mm/dd/yy):
Insurance Company Name		
Insurance Type	☐ HMO ☐ PPO ☐ Other; Specify:	☐ HMO ☐ PPO ☐ Other; Specify:
Copay: (Prim - Spec - U/C)		
Policy / ID #		
Group / Employer #		
Claims Mailing Address		
City, State, Zip		
Policy Owner Name		
Policy Owner Date of Birth		
Relationship to Patient		

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