DOMINION INTERNAL MEDICINE

Patient Registration Form

Date:_____

Patient's Last Name:_____ First:_____Middle:_____Suffix:_____

Mailing Address: _____

City: _____State: _____Zip: _____

Physical Address (if different from mailing):_____

City: _____State: _____Zip: _____

Home Phone#:_____ Cell Phone#:_____

Work Phone#:_____Ext:_____

Email Address: _____

Patient Date of Birth:_____ Patient Sex: Male ☐ Female ☐

Patient Social Security #:_____

Person Responsible for Bill:_____Relationship: _____

Responsible Party Date of Birth: _____

Responsible Party Contact Phone#:_____

Emergency Contact Name: _____

Emergency Contact Relationship: _____Emergency Contact Phone #:_____

Marital Status S_____ M _____ D _____W _____

Language:_____Race:_____Ethnicity:_____Declined:_____

Patient Employer:_____ Retired:_____Unemployed/Homemaker:_____

Primary Insurance:_____Policyholder:_____

Policyholder relationship to patient:_____Policyholder DOB: _____

Member ID#: _____ Group#: _____

Secondary Insurance:_____Policyholder:_____

Policyholder relationship to patient:_____Policyholder DOB: _____

Member ID#: _____ Group#: _____

If this is a Workers' Compensation injury: provide claim information to the front office staff