Grace Internal Medicine

Patient Registration Form

Patient Demographics

Patient Name: _____ DOB:_____ Gender: ___Male ___Female

Street Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____ Would you like to sign up for our patient portal? ___Yes ___No

Race: __Asian __Black/ African-American __Hispanic __Native Hawaiian/Other Pacific __White __Other

Ethnicity: __Hispanic or Latin American _Non-Hispanic or Latin American __Refuse to Report

How did you hear about us? _____

Insurance

Primary Insurance: _____ Subscriber ID#:_____

Subscriber Name: _____ Relationship to the patient: _____

Secondary Insurance:_____ Subscriber ID#:_____

Subscriber Name: _____ Relationship to the patient: _____

EmergencyContact:

Name: _____ Relationship to the Patient: _____ Phone:_____

Pharmacy

Pharmacy Name:_____ Pharmacy Phone: _____

Pharmacy Address: _____