



# Rapides Regional Physician Group

## Patient Registration Form

DATE: \_\_\_\_\_

### PATIENT INFORMATION:

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ SEX: MALE/FEMALE

Ethnicity/Race:  Caucasian  African American  Latin American  Native American  Asian  Hispanic  Other: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

### GUARDIAN:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### EMERGENCY CONTACT (NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

### INSURANCE INFORMATION:

#### **PRIMARY**

INSURED NAME: \_\_\_\_\_

INSURED DATE OF BIRTH: \_\_\_\_\_

INSURED EMPLOYER: \_\_\_\_\_

ID: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

GROUP #: \_\_\_\_\_

YOUR RELATIONSHIP TO INSURED: \_\_\_\_\_

#### **SECONDARY**

INSURED NAME: \_\_\_\_\_

INSURED DATE OF BIRTH: \_\_\_\_\_

INSURED EMPLOYER: \_\_\_\_\_

ID: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

GROUP #: \_\_\_\_\_

YOUR RELATIONSHIP TO INSURED: \_\_\_\_\_

*I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.*

**PATIENT (OR RESPONSIBLE PARTY):** \_\_\_\_\_ **DATE:** \_\_\_\_\_