Rapides Regional Physician Group

Patient Registration Form

DATE: _____

PATIENT INFORMATION:

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ ALTERNATE: _____

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:** _____