ORCHARD FAMILY MEDICINE, PC
PATIENT REGISTRATION FORM

Patients: Please fill out the 2 pages of this form as completely as possible.

PATIENT INFORMATION

Name:_____

SSN:_____ Sex: M F Date of birth:___/___/_____ Age:_____

Residential address:_____

City:_____ State_____Zip Code_____

Mailing address (if different from above)_____

City:_____ State_____ Zip Code_____

Home phone (_____)_____ Work phone (_____)_____

Cell Phone (_____)_____Email_____

May send confidential information to this email** YES NO

Preferred method of contact from our office to you: _____

Pharmacy name, location, and phone number where prescriptions can be faxed in:
_____

Employer_____Title/Position_____

Employer phone (___)_____May we contact you at work? NO YES

Marital status: Single Married

Spouse/partner's name_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship to patient_____

Home phone (____)_____Work phone (____)_____

Please **turn over** and complete the other side…

INSURANCE INFORMATION
***Please attach copies of insurance cards*

PRIMARY INSURANCE
Insurance Company Name/Plan_____

Contract Holder/Subscriber ID#_____

Group #_____Effective Date of Coverage_____

Patient's relationship to contract holder/subscriber: self spouse child other_____

Subscriber's Name_____

Subscriber's Date of Birth_____ Subscriber's SSN#_____

SECONDARY INSURANCE
Insurance Company Name/Plan_____

Contract Holder/Subscriber ID#_____

Group #_____Effective Date of Coverage_____

Patient's relationship to contract holder/subscriber: self spouse child other_____

Subscriber's Name_____ Subscriber's Date of Birth_____

Subscriber's SSN_____

The company may discuss my medical condition/information with the following:

Name of Person	Relationship to patient
_____	_____
_____	_____
_____	_____

How did you hear about Orchard Family Medicine? (friend,yellow pages, ad?)
_____