

**South Ogden Center for Family Medicine
Patient Registration Form**

(Please Print)

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Work _____ Day Evening Home _____ Day Evening
Cellular _____ Pager _____

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Work _____ Day Evening Home _____ Day Evening

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insured's Social Security Number _____ - _____ - _____

Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insured's Social Security Number _____ - _____ - _____

Insurance Company Address _____

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) Signature _____ **Date** _____