CENTRAL MEDICAL GROUP, P.A.

Patient Registration Form

PATIENT INFORMATION:

First Name: ______________________ Last Name: ______________________ Middle Initial: _____

Date of Birth: ______________

Sex: Female ☐ Male ☐ Other ☐ ______________

Marital Status: Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced ☐

Address: ____

City: ______________________ State: __________ Zip: ____________

Home Phone: ______________________ Mobile Phone: ______________________

E-mail: ____

EMERGENCY CONTACT:

First Name: ____________________ Last Name: ____________________ Relationship: ____________

Address: ____ City: ______________ State: _____ Zip: _____

Phone Number: ________________________

ETHNICITY/LANGUAGE/RACE:

Ethnicity: Not Hispanic or Latino ☐ Hispanic or Latino ☐

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race: ____________________ ☐

Primary Language: English ☐ Creole ☐ Spanish ☐ Other ☐ ______________

Primary Care Physician: ______________________________ Phone: ______________________

Referring Doctor: ______________________________

Pharmacy: ______________________________ Phone: ______________________

I hereby authorize direct payment of medical benefits to Dr. ______________ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Patient Name (Please Print): ____

Signature: ______________________________ Date: __________________