Facey Medical Group

With Providence

EMR #: _____

Adult Patient Registration Form

Date: _____

Patient Name: _____ Primary Care Physician (PCP): _____

Preferred Name/Pronouns (if any): _____ Date of Birth (mm/dd/yyyy): ___/___/_____

Social Security #: ___ ___ _____ Gender: ☐ Female ☐ Male ☐ Non-Binary/Transgender

Street Address (home): _____ Relationship Status: ☐ Single ☐ Married/Partnered

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Primary Phone: ☐ Home ☐ Cell

Employer Name: _____ Work Phone (incl. any extension): _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Race (Select one)

☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Hispanic/Latin/Spanish Origin
☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian
☐ Decline to Say

Primary Spoken Language: _____

Ethnicity (Select One):

☐ Hispanic/Latin/Spanish Origin
☐ Non-Hispanic/Latin/Spanish Origin
☐ Decline to Say

Preferred Communication Method *(we may be required to send some types of communications by mail regardless of indicated preference)*

☐ Phone ☐ Mail ☐ Email: _____ ☐ Do Not Contact

Patient's Financial Responsibility *(if this is you, write "self" and continue to the next section)*

Name: _____ Relationship to Patient: _____

Social Security #: ___ ___ _____ Phone: _____ Date of Birth (mm/dd/yyyy): ___/___/_____

Address : _____ City: _____ State: _____ ZIP: _____

Employer Name: _____ Work Phone (incl. any extension): _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact Information

THIRD PARTY CONSENT ON FILE? ☐ YES ☐ NO

Emergency Contact : _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Primary Phone: ☐ Home ☐ Cell

Street Address (if different from above): _____

City: _____ State: _____ ZIP: _____ Work Phone (incl. any extension): _____

Secondary Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Primary Phone: ☐ Home ☐ Cell

Address : _____ City: _____ State: _____ ZIP: _____

Health Insurance Information

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO

Primary Health Insurance

Insurance Company: _____
Insurance Phone #: _____
Subscriber's Name: _____
Subscriber's Employer: _____
Subscriber's Date of Birth: ___/___/_____
Subscriber's Social Security #: ___ ___ _____
Policy #: _____
Group #: _____
Effective Date: ___/___/_____

Secondary Health Insurance (if any)

Insurance Company: _____
Insurance Phone #: _____
Subscriber's Name: _____
Subscriber's Employer: _____
Subscriber's Date of Birth: ___/___/_____
Subscriber's Social Security #: ___ ___ _____
Policy #: _____
Group #: _____
Effective Date: ___/___/_____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payments to **Facey Medical Group and Providence Facey Medical Foundation**, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this Assignment may be honored.

PATIENT SIGNATURE: _____ **DATE:** ___/___/_____

EMPLOYEE/WITNESS SIGNATURE: _____ **DATE:** ___/___/_____