PIEDMONT MEDICAL
ASSOCIATES

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ Sex: ☐ Male ☐ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Marital status**: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Email: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ☐ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____ Social security number _____

Relation to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____ **Sex**: ☐ Male ☐ Female

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ☐ Self-pay (no insurance)

Primary insurance: _____ **Patient relation to subscriber**: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary insurance: _____ **Patient relation to subscriber**: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer size**: ☐ 0 – 19 employees ☐ 20 – 99 ☐ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ☐ **Yes** or ☐ **No**

126522P Rev. 04/14

DO NOT SCAN