



# Saint Alphonsus Medical Group

## PATIENT REGISTRATION: PATIENTS 18 YEARS AND OLDER

Date: \_\_\_\_\_

<b>Patient</b>	Last Name _____ First Name _____ Initial _____
	Date of Birth _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Email _____
	Address _____ City _____ State _____ Zip _____
	Phone (Home) _____ Phone (Cell) _____
	Phone (Work) _____ Preferred Message/Contact Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Race (please circle) American Indian Asian Black Hawaiian/Pacific Islander White Other (Multi-racial) Unknown Declined
	Ethnicity (please circle) Hispanic/Latino Not Hispanic/Latino Other _____
	Preferred Language _____
	Employer _____
	Employer Address _____ City _____ State _____ Zip _____
Have you been seen at a St Alphonsus Clinic or Express Care Clinic in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who was your last provider? _____	
Preferred Pharmacy _____ Major Crossroads _____	
<b>Health Insurance</b> <small>(Clinic: If unable to scan card, make copy and attach. If card unavailable, write info on this form.)</small>	<b>Primary Insurance</b> _____ <i>(Employer ONLY needed if different from above.)</i>
	Policy Holder Name _____ Date of Birth _____
	Employer _____ Relationship to Patient _____
	Employer Address _____ City _____ State _____ Zip _____
	<b>Secondary Insurance</b> _____
	Policy Holder Name _____ Date of Birth _____
Employer _____ Relationship to Patient _____	
Employer Address _____ City _____ State _____ Zip _____	
<b>Additional Contact</b> <small>(not living with you)</small>	Last Name _____ First Name _____ Phone Number _____
	Address _____ City _____ State _____ Zip _____
	Relationship to Patient _____
<b>Advanced Directives</b> <small>(Living Will)</small>	Would you like more information about Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Brochure Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No

People assisting with paperwork:

Interpreter's name \_\_\_\_\_ Interpreter's Signature and/or ID # \_\_\_\_\_ Date and Time \_\_\_\_\_

Office Staff name \_\_\_\_\_ Office Staff Signature \_\_\_\_\_ Date and Time \_\_\_\_\_

Place patient sticker here or handwrite

Name: \_\_\_\_\_

DOB: \_\_\_\_\_