PATIENT REGISTRATION

Pullman Family Medicine

Patient's Legal Name: _____ S.S. #:_____
(Last) (First) (Middle Initial)

Preferred Name: _____

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-7. Thank you.

(1) Patient's Birthdate: _____

(2) Marital Status: _____

(3) Patient's Gender: _____

(4) Race (Check One)
- □ American Indian/Alaska Native
- □ Asian
- □ Native Hawaiian or Pacific Islander
- □ African American or Black
- □ Hispanic or Latino
- □ White
- □ Other Race
- □ Declined

(5) Ethnicity (Check One)
- □ Not Hispanic or Latino
- □ Hispanic or Latino
- □ Declined

(6) Primary Language (Please List)
- □ _____

(7) Preferred Method of Contact:

□ Portal Email □ Letter □ Primary Phone □ Secondary Phone

Local Address: _____ City: _____ State:_____ Zip Code: _____

Billing Address: _____ City: _____ State:_____ Zip Code: _____

Primary Number:_____ Secondary number: _____

Email: _____ May we contact you via Patient Portal? Yes_____ No_____

Employer Name & Address: _____ Occupation: _____

If Patient is under age of 18, please fill out the next two sections:

1. Father's Name: _____ DOB:_____ S.S. #: _____
(Last) (First) (Middle Initial)

Address: _____ City:_____ State:_____ Zip Code: _____

Home number:_____ Work number: _____ Cell number: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

2. Mother's Name: _____ DOB:_____ S.S. #: _____
(Last) (First) (Middle Initial)

Address: _____ City: _____ State: _____ Zip Code:_____

Home number:_____ Work number:_____ Cell number: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Name of Other: **□ Stepmother □ Stepfather □ Grandparent □ Foster Parent □ Legal Guardian □ Power of Attorney**

Name: _____ Gender:_____ DOB:_____ S.S. #: _____
(Last) (First) (Middle Initial)

Address: _____ City: _____ State: _____ Zip Code: _____

Home number: _____ Work number: _____ Cell number: _____

Email: _____

Employer Name & Address:_____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
(Last) (First)

Home number:_____ Work number: _____ Cell number: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ City: _____State:_____

Preferred Mail Order Pharmacy: _____

Phone number: _____

Address: _____

INSURANCE INFORMATION

Name of Primary Insurance:_____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(Last) (First) (Middle Initial)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Customer Service Phone #: _____ Relationship to Patient: _____

Effective Date: _____

Name of Secondary Insurance** (If Applicable)**: _____

Subscriber's Name: _____ Birthdate: _____
(Last) (First) (Middle Initial)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Customer Service Phone #: _____ Relationship to Patient: _____

Tertiary Insurance** (If Applicable) **: _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(Last) (First) (Middle Initial)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Customer Service Phone #: _____ Relationship to Patient: _____

FAMILY ASSOCIATION INFORMATION

– (Please list names of all household members and their birthdate. Thank You.) –

Name	Birthdate
_____	_____
_____	_____
_____	_____
_____	_____

I acknowledge the above Insurance/Demographic information is correct and that regardless of my insurance status I am solely responsible for payment of any professional services rendered to me, or on my behalf, whether or not paid by my insurance company.

Signature of Patient or Legal Guardian: _____Date:_____

Printed Name: _____ Relationship to Patient: _____