St. Dominic Medical Associates

Location: _____

Patient # _____

Registration Sheet

Date: _____

PATIENT INFORMATION

Patient _____
Last First Middle

Mailing Address _____

_____
City State Zip

Hm.Ph. _____ Cell .Ph. _____

Work Ph. _____ Employer _____

Employer Address: _____
Street

_____
City State Zip

Social Security # _____

Date of Birth ____/____/_____ Age: _____

Sex: M or F Marital Status: S M D W (circle one)

Is visit related to an injury? Yes No (circle one)

Date of Injury _____

Email Address _____

Injury: Auto Work Other _____(circle one)

Ethnic Origin: Asian, African American, Hawaiian, Native American, other, unknown, white (Caucasian)

RESPONSIBLE PARTY INFORMATION

If patient is minor, parent or guardian completing registration sheet

Name _____
Last First Middle

Mailing Address _____

_____
City State Zip

Hm Ph. _____ Cell Ph. _____ Work Ph . _____ Employer _____

Employer Address: _____
Street City State Zip

Social Security # _____

Date of Birth ___/___/___ Sex: M or F (circle one)

Marital Status: S M D W (circle one)

INSURANCE INFORMATION

PRIMARY

Insurance Company _____

Insured's Name _____
Last First Middle

Address _____

_____ _____ _____
City State Zip

Patient's Relationship to Insured: Self Child Spouse Other

Group # _____ Policy # _____

Effective Date _____

Hm.Ph. _____ Wk.Ph. _____ Ext. _____

Date of Birth _____ Sex: M or F

Social Security # _____ Employer _____

SECONDARY/SUPPLEMENTAL

Insurance Company _____

Insured's Name _____
Last First Middle

Address _____

_____ _____ _____
City State Zip

Patient's Relationship to Insured: Self Child Spouse Other

Group # _____ Policy _____

Effective Date _____

Hm.Ph. _____ Wk.Ph. _____ Ext. _____

Date of Birth _____ Sex: M or F

Social Security# _____ Employer _____

How did you hear about our clinic/physician? _____

In Case Of Emergency Contact _____ _____ _____
Name Relationship Phone

Primary Care Physician _____

Method of Payment ( ) Cash ( ) Check ( ) Credit Card