Patient Registration Form

Last Name	**First Name**	MI	Date
Maiden Name	**Date of Birth**	Age	**Gender**

Race ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒ Hispanic or Latino
❒ Native Hawaiian or Other Pacific Islander ❒ White ❒ Unknown

Ethnicity ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Unknown ❒ Decline

Preferred Language

Street Address

City	**State**	**Zip**
Telephone (Home)	**(Work)**	**(Cell)**

Email Address May we contact you by email? ❒ Yes ❒ No

Where may we leave messages? ❒ Home ❒ Work ❒ Cell

Where do you prefer to receive your appointment reminder message? ❒ Home ❒ Cell ❒ Email ❒ Text

Parent(s) / Guardian(s) Name / Healthcare proxy

Do you have advance directives? ❒ Yes ❒ No

Marrital Status ❒ Married ❒ Partnership ❒ Separated ❒ Divorced ❒ Widowed ❒ Single

Live with ❒ Spouse ❒ Partner ❒ Parents ❒ Children ❒ Friends ❒ Alone

Employment Status ❒ Employed ❒ Unemployed ❒ Full time student ❒ Part time student

Occupation	Hours per week
Employer Name and Address	

Emergency Contact	**Relationship**	**Contact Phone**
Primary Care Physician	Preferred Pharmacy	
How did you hear about Biologic Healthcare?		

*Required fields are indicated in **BOLD** above

Insurance Verification: ❒ BC/BS ❒ Cigna ❒ MVP ❒ CBA ❒ Medicaid/VHAP ❒ Medicare ❒ Self-Pay

ID/Policy #:	Group/Acct #
Subscriber Name:	Subscriber/ Policyholder Date of birth:

biologic HEALTHCARE

sensible approaches to your well-being

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