ANDERSON MEDICAL GROUP

PATIENT REGISTRATION & DEMOGRAPHICS

Last Name _____ First Name _____Middle Initial ____

Date of Birth_____ SS# _____ Sex: Female, Male, or Undifferentiated

Address _____

City_____ State _____ Zip _____

Home Phone _____Cell Phone _____ Work Phone _____

Marital Status _____ Preferred Language _____ Race_____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Provide

Interpreter Needed? ___ Yes ___ No

Email Address for Patient Portal_____

Optional: Preferred Pronouns _____

Primary Insurance:

Insurance Name _____

Policy#_____Group#_____

Subscriber Name _____ Date of Birth_____

SS# _____ Patient Relationship to Subscriber_____

Secondary Insurance:

Insurance Name _____

Policy#_____Group#_____

Subscriber Name _____ Date of Birth_____

SS# _____ Patient Relationship to Subscriber_____

Responsible Party/Guarantor :

Person financially responsible for payment on the patient account. Usually the patient if over 18 years of age.

Is the Patient also the Guarantor? ___Yes___No If Yes, skip to the *Emergency Contact* Section

Guarantor Name: _____ Date of Birth: _____SS#_____

Address_____City_____State_____Zip _____

Relationship to Patient:_____

Emergency Contact: ☐ Appointment ☐Clinical ☐Financial Information

Name:_____ Phone:_____Relationship to Patient:_____

Signature of Patient/Authorized Person **Relationship to Patient** Date