FRESH MEDICAL FAMILY CLINIC
Let Our Family Care For Yours

PATIENT REGISTRATION FORM

PATIENT INORMATION

Last Name First Name MI

DOB SSN# DL# STATE

☐ Male ☐ Female E-Mail Address*_____ Patient Portal: (circle one) Y or N

Address City, State, Zip

Mailing Address (if different) City, State, Zip

Marital Status	☐Single	☐Married	☐Divorced	☐Widowed	☐Separated
Language	☐English	☐Other			
Race	☐American Indian/Alaskan Native	☐Black/African American ☐White	☐Native Hawaiian/Pacific Islander	☐Declined to Specify ☐Unknown	☐Asian ☐Other
Ethnicity	☐Hispanic/ Latino	☐Non Hispanic/Latino	☐Declined to Specify		
Citizenship	☐US	☐Other			

CONTACT INFORMATION

Patient: Home:_____ Work:_____ Cell:_____
Spouse: Name:_____ Home:_____ Work:_____
*Father: Name:_____ Home:_____ Work:_____
*Mother: Name:_____ Home:_____ Work:_____
**only required if patient is under 18*
Emergency Contact Name:_____ Phone:_____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Carrier: Co-Pay $
Policy # Group# Co-Ins%
Insured Address: Phone:
Insured Name: Employer:
Insured Address: DOB: Male/Female
Phone: SSN:
Relationship to insured:

Secondary Insurance Carrier: Co-Pay $
Group # Policy# Co-Ins%
Insured Address: Phone:
Insured Name: Employer:
Insured Address: DOB: Male/Female
Phone: SSN:
Relationship to insured:

Mother's Name First _____ Maiden_____

PREFERRED PHARMACY OF CHOICE:_____