



Reid Physician Associates

PATIENT REGISTRATION FORM – PLEASE COMPLETE IN FULL

Date _____

Patient Name (first, middle, last): _____ Sex: **M F**

Social Security #: _____ Date of Birth: _____ Marital Status: **S M D W**

Patient Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: (H) _____ (C) _____ (W) _____

Email: _____ May we use this to confirm appointments? **Y N**

Primary Care Physician: _____ Referred By: _____

Employer Name: _____ Status: **Full-Time Part-Time Retired None**

Employer Address: _____ City: _____ State: _____ Zip: _____

Student Status if applicable: **Full-Time Part-Time** Name of College/Univ/School.: _____

In case of emergency, please list two people we may contact:

Name: _____ Relationship: _____ Phone: _____

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

Name: _____ Relationship: _____ Phone: _____

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

Primary Insurance Co.: _____ Policy/ID #: _____ Group #: _____

Insured Party: **Self Spouse Parent**

Insured name if not self: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Co.: _____ Policy/ID #: _____ Group #: _____

Insured Party: **Self Spouse Parent**

Insured name if not self: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Tertiary: _____ Policy/ID #: _____ Group #: _____