Patient Registration

Patient Information

PATIENT NAME (First, MIddle, Last) | **DATE OF BIRTH** | **PRIMARY CARE PROVIDER**

STREET OR MAILING ADDRESS (P.O. Box) | **CITY** | **STATE** | **ZIP CODE**

HOME PHONE | **CELL PHONE** | **WORK PHONE** | **EMAIL ADDRESS** (Required for Patient Portal)

PRIMARY LANGUAGE

PREFERRED CONTACT METHOD (Check all that apply): ☐ Home Address (Letter) ☐ Home Phone ☐ Cell Phone

EMPLOYER

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Active Duty

STUDENT STATUS: ☐ Full Time ☐ Part Time ☐ Not a Student

EMERGENCY CONTACT NAME | **RELATIONSHIP TO PATIENT** | **PHONE** DAYTIME | EVENING

BIRTH SEX
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

CURRENT GENDER
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

PREFERRED PRONOUN
- ☐ Choose not to disclose
- ☐ She, Her, Hers
- ☐ He, Him, His
- ☐ Ze, Hir
- ☐ They, Them, Theirs
- ☐ Other: ____________

GENDER IDENTITY
- ☐ Choose not to disclose
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify): ____________

SEXUAL ORIENTATION
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, or homosexual
- ☐ Something else (please describe): ____________

MARITAL STATUS
- ☐ Choose not to disclose
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Annulled
- ☐ Widowed
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Life Partner

RACE
- ☐ Choose not to disclose
- ☐ American Indian/Alaskan Native
- ☐ White/Caucasian
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Other: ____________

ETHNICITY
- ☐ Choose not to disclose
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Other: ____________

Responsible Party

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Guardian ☐ Self ☐ Spouse ☐ Other: ____________

RESPONSIBLE PARTY NAME (First, Middle, Last) | **DATE OF BIRTH** | **EMPLOYER**

SEX: ☐ Male ☐ Female ☐ Undifferentiated

ADDRESS | **HOME PHONE** | **WORK PHONE**

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID# | **GROUP#**

SUBSCRIBER NAME (Policy Holder) | **DATE OF BIRTH**

ADDRESS | **PHONE**

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE CARRIER

INSURANCE ID# | **GROUP#**

SUBSCRIBER NAME (Policy Holder) | **DATE OF BIRTH**

ADDRESS | **PHONE**

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

CONTINUED ON REVERSE

If you are here because of an injury, is it: ☐ **Work Related** ☐ **Auto Related** ☐ **Neither**

All Payment Is Due at Time of Service

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of service. I will be responsible for fees and charges according to Frederick Health Medical Group and my health plan. If I do not provide a **valid** insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Frederick Health Medical Group and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages and/or an automatic dialing device ("auto dialer"), by text message, or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE DATE

RELATIONSHIP TO PATIENT