First Physicians Group of Sarasota **Date: _____**

Patient Registration Information **Provider:**

Social Security #: _____

_____

(First Name) (M.I.) (Last Name) (Suffix)

Sex: _____ M _____ F Date of Birth: _____

Legal Marital Status: Single____ Married____ Widowed____ Divorced____

Our medical providers are participating in a government program that encourages the adoption of electronic health records. This technology is supposed to lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patient. As part of this program, the government requires us to record the following demographic information about you:

RACE

- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Hawaiian Native/Pac Island
- ☐ Other Race
- ☐ White

ETHNICITY

- ☐ Latino/Hispanic
- ☐ Other
- ☐ Refuse

Language: _____

Employed ____ Part-time Student ____ Full-time Student____ Retired____

Employer/School: _____

Home Address _____

City_____ State _____ Zip Code_____

Email address _____ Cell Phone # (____) _____

Home Phone # (____) _____ Work Phone # (____) _____ Ext_____

REFERRED BY: _____

Previous Name_____

Spouse/Significant Other/Parent or Guardian_____

Occupation of Spouse/Significant Other/Parent or Guardian_____

In Case of Emergency Notify_____ Phone_____

Relationship to Patient_____ Phone_____

Second Address/Alternate Billing Address: _____

City_____ State _____ Zip Code_____

Date: From _____ To _____ Telephone (____) _____

Preferred Pharmacy: Name:_____ Location: _____Telephone: _____

MEDICARE PATIENTS: Medicare does not always pay your bills first. Please indicate which insurance pays your bills first by providing the insurance information in the Primary Insurance section of this form.

Primary Insurance (Insurance company that pays first) _____

Address _____

City_____ State _____ Zip Code_____

Group name or #:_____ Policy Dates From _____ To _____

Insurance ID #_____

Primary Insurance Subscriber/Policyholder Information:

_____

Last Name First Name (M.I.)

Address _____

City_____ State _____ Zip Code_____

Relationship of Policy Holder to Patient_____ Sex: _____M _____F

Date of Birth_____ Social Sec. #_____

Home Phone No. (_____)_____

Insured's Employer_____ Employer Insurance Plan: _____Yes _____No

Secondary Insurance (Insurance that pays second) _____

Address _____

City_____ State _____ Zip Code_____

Group name or #:_____ Policy Dates From _____ To _____

Insurance ID #_____

Secondary Insurance Subscriber/Policyholder Information:

_____

Last Name First Name (M.I.)

Address _____

City_____ State _____ Zip Code_____

Relationship of Policy Holder to Patient_____ Sex: _____M _____F

Date of Birth_____ Social Sec. #_____

Home Phone No. (_____)_____

Insured's Employer_____ Employer Insurance Plan: _____Yes