

**COLLEGE PARK FAMILY CARE CENTER
PATIENT REGISTRATION**

Today's Date _____

Primary Doctor _____

PATIENT INFORMATION

NAME: _____ **BIRTH DATE:** _____
(First) (Middle Initial) (Last)

MARITAL STATUS: **Single** **Married** **Separated** **Divorced** **Widow(ed)** **GENDER:** **Female** **Male**

ADDRESS: _____
(Number and Street) (Apartment #) (City) (State) (Zip Code)

SOCIAL SECURITY #: _____ **HOME PHONE:** _____ **MOBILE PHONE:** _____

EMPLOYER or SCHOOL: _____ **EMPLOYER PHONE:** _____

ADDRESS: _____
(Number and Street) (City) (State) (Zip Code)

GUARANTOR INFORMATION (Person who signed Financial Responsibility)

NAME: _____ **BIRTH DATE:** _____
(First) (Middle Initial) (Last)

RELATIONSHIP TO PT: _____

ADDRESS: _____
(Number and Street) (Apartment #) (City) (State) (Zip Code)

SOCIAL SECURITY #: _____ **HOME PHONE #:** _____ **MOBILE PHONE #:** _____

EMPLOYER: _____ **EMPLOYER PHONE #:** _____

ADDRESS: _____
(Number and Street) (City) (State) (Zip Code)

IN CASE OF AN EMERGENCY

NAME: _____	RELATIONSHIP: _____
HOME #: _____	Employer / MOBILE #: _____
NAME: _____	RELATIONSHIP: _____
HOME #: _____	Employer / MOBILE #: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME _____	INSURANCE NAME _____
ID# _____ GROUP# _____	ID# _____ GROUP# _____
POLICY OWNER NAME _____	POLICY OWNER NAME _____
POLICY OWNER DATE OF BIRTH / RELATION TO PT _____	POLICY OWNER DATE OF BIRTH / RELATION TO PT _____
CLAIMS MAILING STREET ADDRESS _____	CLAIMS MAILING STREET ADDRESS _____
CLAIMS MAILING CITY, STATE, ZIP CODE _____	CLAIMS MAILING CITY, STATE, ZIP CODE _____