Eastside Medical Group
Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr./Sr.

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address _____

City, State _____ ZIP_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Social Security Number _____-_____-_____

Race/Ethnicity ☐Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic or Latino

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Declined

Language ☐ English ☐ Spanish ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Primary Care Provider (PCP) _____ Referring Provider _____

Pharmacy _____ Pharmacy Phone_____

Employer Name _____Employer Phone _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Relationship to Patient _____

Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

☐ Self

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____

(If different from patient)

Address _____City, State _____ ZIP _____

Employer _____ Employer Phone Number_____

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Primary Insurance _____ Insured _____

Secondary Insurance _____ Insured _____

How did you hear about us?

☐ Website ☐ Internet Search ☐ Internet Advertisement ☐ Family/Friends ☐ Facebook ☐ Magazine/Newspaper Ad

☐ Another healthcare provider: _____ ☐ Physician Directory ☐ Hospital MD Referral – Medline