Blue River Family Medicine

Patient Registration Form

Personal Information

Name Last, First: Middle: Preferred Name:

Address: City: State: Zip Code:

Date of Birth: Social Security Number:

Home phone: Cell phone: Email:

Consent to text: YES NO Contact Preference: Phone Text Email

Occupation: Business Phone:

Employer: Address: City: State: Zip Code:

Gender: ☐ Male ☐ Female Race/Ethnicity: Preferred Language:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Emergency Contact Information

Name: Relationship:

Home phone: Cell phone:

Guarantor

Last Name: First Name: Middle Name:

Date of birth: Social security number: Phone number:

Address: City: State: Zip Code:

Employer: Business Phone:

Insurance Information

Primary Insurance: Identification #: Group#:

Subscriber's Name: Date of Birth:

Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance: Identification #: Group #:

Subscriber's Name: Date of Birth:

Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Signature: Today's Date:

Signature of Responsible Party: ☐ Parent ☐ Guardian