FIRST PHYSICIANS GROUP
*of Sarasota Memorial Health Care System*

# Patient Registration Information

**Date**: _____ **Provider**: _____

**Social Security #:** _____ **Date of Birth**: _____

_____

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

**Sex:** _____ **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

Preferred Language _____

Employed _____ Part-time Student _____ Full-time Student_____ Retired_____

Employer/School: _____

Home Address _____

City_____ State _____ Zip _____ Email _____

Cell # (____) _____ Home # (____) _____ Work # (____) _____ 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 2 _____

**Second Address/Alternate Billing Address**: _____

City_____ State _____ Zip Code_____

Dates: 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/#:_____ 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. (_____)_____ Cell Phone No. (_____) _____

Insured's Employer_____ Employer Insurance Plan: _____Yes _____No

## Secondary Insurance *(Insurance that pays second)* _____

Address _____

City_____ State _____ Zip Code_____

Group name/#:_____ 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. (_____)_____ Cell Phone No. (_____) _____

Insured's Employer_____ Employer Insurance Plan: _____Yes _____No