PROVIDA FAMILY MEDICINE PATIENT REGISTRATION FORM

_____ **Male**☐ **Female**☐

Last name First M.I.

_____-_____-_____ _____/_____/_____ **Married**☐ **Single**☐ **Widow**☐

Social Security Number Date of Birth

Race: **White**☐ **Hispanic**☐ **Asian**☐ **Black/African American**☐
Hawaiian☐ **Native American**☐ **Native Alaskan**☐ **Other**☐

Who referred you to our office? _____

Ethnicity: **Non-Hispanic**☐ **Hispanic**☐ **email address** _____

_____ (_____)_____-_____

Address Number Street Apt Home Phone

_____ (_____)_____-_____

City State Zip Cell Phone

_____ (_____)_____-_____X____

Employer Company Name Work Telephone Ext.

_____ (____)_____-_____X____

Spouse Name Last First M.I. Telephone Number Ext.

_____-_____-_____ _____/_____/_____

Social Security Number Date of Birth

Emergency Contact

_____ _____ (____)_____-_____

Last First M.I. Relationship to Patient Telephone Number

MOTHER'S INFORMATION **MINORS** **FATHER'S INFORMATION**

_____ _____

Last name First M.I. Last Name First M.I.

_____ _____

Street Address City State Zip Street Address City State Zip

_____/_____/_____ _____/_____/_____

Mother's Date of Birth Father's Date of Birth

(_____)_____-_____ (_____)_____-_____

Telephone Number Telephone Number

_____-_____-_____ _____-_____-_____

Mother's Social Security Number Father's Social Security Number

Preferred Pharmacy Name/Pharmacy City _____/_____

☐ **I HAVE MEDICAL INSURANCE • PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO I.D.**

I authorize direct payment of medical benefits to Provida Health Center, S.C. for medical services rendered. I authorize Provida Health Center, S.C. to release any medical or relevant information that might be necessary for either medical care or in processing applications for financial benefit. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

☐ **I DO NOT HAVE MEDICAL INSURANCE • PLEASE PRESENT YOUR PHOTO I.D.**

I grant permission to the medical providers at Provida Health Center, S.C. to access my prescription history from external sources.

I acknowledge that the information provided in this registration form is true and accurate.

Signature_____**Date**_____