Patient Registration

Frederick Health Medical Group

Patient Information

PATIENT NAME (First, Middle, Last, Suffix) _____ **DATE OF BIRTH** _____ **PRIMARY CARE PROVIDER** _____

STREET OR MAILING ADDRESS (P.O. Box) _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

EMAIL ADDRESS (Required for Patient Portal) _____

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

PREFERRED CONTACT METHOD (Check all that apply): ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Home Address (Letter) ☐ Portal

EMPLOYER: _____

EMPLOYER PHONE: _____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Homemaker ☐ Active Military ☐ Unknown

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT NAME _____ **RELATIONSHIP TO PATIENT** _____ **PHONE:** **DAYTIME** _____ **EVENING** _____

PRONOUN
- ☐ Choose Not To Disclose
- ☐ He, Him, His
- ☐ She, Her, Hers
- ☐ They, Them, Theirs
- ☐ Ze, Hir

BIRTH SEX
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

LEGAL SEX
- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Other
- ☐ Unknown/Undifferentiated

GENDER IDENTITY
- ☐ Choose not to disclose
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify):

_____

SEXUAL ORIENTATION
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, or homosexual
- ☐ Something else (please describe):

_____

PRIMARY LANGUAGE: _____ **INTERPRETER NEEDED?** ☐ Yes ☐ No

MARITAL STATUS
- ☐ Annulled
- ☐ Choose not to disclose
- ☐ Divorced
- ☐ Legally Separated
- ☐ Life Partner
- ☐ Married
- ☐ Married, Common Law
- ☐ Single
- ☐ Unknown
- ☐ Widowed

RACE
- ☐ American Indian/Alaskan Native
- ☐ Decline to Answer
- ☐ Unknown/Unable to Answer
- ☐ Asian
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Other: _____

ETHNICITY
- ☐ Cuban
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ Decline to answer
- ☐ Mexican or Chicano
- ☐ Other Hispanic Origin
- ☐ Unknown/Unable to answer

ORGAN DONOR: ☐ Yes ☐ No

VETERAN STATUS: _____

CONTINUED ON REVERSE

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID# GROUP#

SUBSCRIBER NAME (Policyholder) DATE OF BIRTH

ADDRESS PHONE

RELATIONSHIP TO PATIENT:

☐ Same as Patient ☐ Parent
☐ Spouse ☐ Other _____

SECONDARY INSURANCE CARRIER

INSURANCE ID# GROUP#

SUBSCRIBER NAME (Policyholder) DATE OF BIRTH

ADDRESS PHONE

RELATIONSHIP TO PATIENT:

☐ Same as Patient ☐ Parent
☐ Spouse ☐ Other _____

If you are here because of an injury, is it: ☐ **Work Related** ☐ **Auto Related** ☐ **Neither** _____ DATE OF INJURY

Responsible Party/Guarantor

RESPONSIBLE PARTY NAME (First, Middle, Last) DATE OF BIRTH EMPLOYER

ADDRESS HOME PHONE WORK PHONE

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Guardian ☐ Self ☐ Spouse ☐ Other _____

SEX: ☐ Female ☐ Male ☐ Undifferentiated

All Payment Is Due at Time of Service

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of service. I will be responsible for fees and charges according to Frederick Health Medical Group and my health plan. If I do not provide a **valid** insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Frederick Health Medical Group and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages and/or an automatic dialing device ("auto dialer"), by text message, or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE DATE

RELATIONSHIP TO PATIENT