PrimeHealth
PRIMARY CARE

# Patient Registration - Please Print

Today's Date: _____ Email Address: _____

Patient Name: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Pref Y / N Home Phone: _____ Pref Y / N

Age: _____ Date of Birth: ____ / ____ / ____ Sex: □ M □ F Social Security #: _____

**Emergency Contact Name:** _____ **Phone:** _____ **Relationship:** _____

**Marital Status:** □ Single □Married □Divorced □Separated □Widowed □Minor

**Military Status:** □ Active □ Retired □ Spouse of Dependent □ Child of Dependent

**Ethnicity:** □Hispanic or Latino □Not Hispanic or Latino □Unknown □Declined to Specify

**Race:** □American Indian/ Alaskan Native □Asian □Black or African American □White
□Native Hawaiian or Other Pacific Islander □Other Race □Declined to Specify

Primary Insurance Carrier: _____ Policy #: _____

Secondary Insurance Carrier: _____ Policy #: _____

Insurance Policy Holder: _____ Date of Birth: _____ / _____ / _____

If Minor, Responsible Party: _____

If different address than above: _____

**Preferred Pharmacy**: _____

**How did you hear of PrimeHealth?**

□Physician □Pharmacy □Business □Soc. Media □Family/Friend □Print Media □Google
□Drive by/Walk-in □Publix □Other _____

**Please let us know if your visit is due to an □ AUTO Accident □ Workers' Compensation**

**Reason for the Visit:** _____

_____