pinnacle
MEDICAL GROUP, INC.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LEGAL LAST NAME	LEGAL FIRST NAME	MI	MARITAL STATUS	DATE OF BIRTH	AGE	SEX

PATIENT'S ADDRESS	APT/SPACE#	CITY	STATE	ZIP	HOME PHONE NO.	CELL PHONE NO.

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	SOCIAL SECURITY NUMBER	OTHER NAMES USED

E-MAIL ADDRESS	PHARMACY NAME	PHARMACY CITY	PHARMACY CROSS STREETS

*ETHNIC ORIGIN (CIRCLE ONE)	*PRIMARY LANGUAGE	*COUNTRY OF BIRTH
Hispanic or Latino Non-Hispanic/Latino Unknown/Other Decline to Answer		

*RACE (CIRCLE ONE)

American Indian/Alaskan Native Asian Black/African American Native Hawaiian Pacific Islander Undetermined

White Decline to Answer

PERSON RESPONSIBLE FOR PATIENT'S EXPENSE

LAST NAME	FIRST NAME	MI

ADDRESS

PHONE NO.	DATE OF BIRTH	SOCIAL SECURITY NO.

RELATIONSHIP TO PATIENT	EMPLOYER NAME	EMPLOYER PHONE NO.

SPOUSE OF PERSON RESPONSIBLE

LAST NAME	FIRST NAME	MI

ADDRESS

PHONE NO.	DATE OF BIRTH	SOCIAL SECURITY NO.

RELATIONSHIP TO PATIENT	EMPLOYER NAME	EMPLOYER PHONE NO.

EMERGENCY CONTACTS

PRIMARY	PHONE NO.	SECONDARY	PHONE NO.

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S EMP.	RELATIONSHIP TO PT.
SECONDARY INSURANCE NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S EMP.	RELATIONSHIP TO PT.

FOR OFFICE USE ONLY

GUARANTOR #:	PATIENT #:

I certify that the above information is correct to the best of my knowledge.

_____ _____

Signature of Patient – if minor, signature of person responsible Date

*Federal and State Requirements