Date: ________________ Provider: ______________________________

First Name	M.I.	Last Name	Suffix

Sex: ❑ Male ❑ Female Date of Birth:

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
❑ White
❑ Hispanic or Latino
❑ Hawaiian Native / Pac Island
❑ Other Race:____________________

ETHNICITY

❑ Latino / Hispanic
❑ Other: ____________________
❑ Refuse

Language:

❑ Employed ❑ Part-Time Student ❑ Full-Time Student ❑ Retired

Employer / School:

Home Address:

City: State: Zip Code:

Email Address: Cell Phone #: (   )

Home Phone #: (   ) Work Phone #: (   ) 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:

Second Address / Alternate Billing Address:

City: State: Zip Code:

Date: From to Telephone #: (   )

Preferred Pharmacy: Name: ______________________________

Location: ______________________________

Telephone: ______________________________

SARASOTA MEMORIAL HEALTH CARE SYSTEM

NEWTOWN INTERNAL MEDICINE

PATIENT REGISTRATION

PLACE PATIENT ID LABEL HERE

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 or #:	Policy Dates From	To
Insurance ID #:		
PRIMARY INSURANCE SUBSCRIBER / POLICY HOLDER INFORMATION		
Last Name	First Name	M.I.
Address:		
City:	State:	Zip Code:
Relationship of Policy Holder to Patient		Sex: ❑ Male ❑ Female
Date of Birth:	Social Security #:	
Home Phone #: ( )		
Insured's Employer:		Employer Insurance Plan: ❑ Yes ❑ No
Secondary Insurance (Insurance company that pays second):		
Address:		
City:	State:	Zip Code:
Group Name or #:	Policy Dates From	To
Insurance ID #:		
SECONDARY INSURANCE SUBSCRIBER / POLICY HOLDER INFORMATION		
Last Name	First Name	M.I.
Address:		
City:	State:	Zip Code:
Relationship of Policy Holder to Patient		Sex: ❑ Male ❑ Female
Date of Birth:	Social Security #:	
Home Phone #: ( )		
Insured's Employer:		Employer Insurance Plan: ❑ Yes ❑ No

SARASOTA MEMORIAL HEALTH CARE SYSTEM

NEWTOWN INTERNAL MEDICINE

PATIENT REGISTRATION