FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Patient Registration Information

Date: _____ **Provider**: _____

Social Security #: _____ **Date of Birth**: _____

_____
(First Name) **(M.I.)** **(Last Name)** **(Suffix)**

Sex: _____ **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
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Refuse
- ☐ Don't Know

Ethnicity
- ☐ Latino/Hispanic
- ☐ Not Hispanic or Latino
- ☐ Other _____
- ☐ Refuse

Preferred Language _____

Employed _____ Part-time Student _____ Full-time Student_____ Retired_____

Employer/School_____

Home Address _____

City_____State_____Zip_____Email _____

Cell # (_____)_____Home # (____)_____Work # (____)_____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 2 _____

Second Address/Alternate Billing Address: _____

City_____ State_____Zip Code_____

Dates: From _____ To _____ Telephone (____) _____

Preferred Pharmacy: Name:_____Location:_____Telephone: _____

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/#:_____Policy Dates: From_____To_____Insurance ID #_____

Primary Insurance Subscriber/Policyholder Information:

_____

Last Name First Name (M.I.)

Address _____

City_____ State _____ Zip Code_____

Relationship of Policy Holder to Patient_____Sex:_____M _____F

Date of Birth_____ Social Sec. #_____

Home Phone No. (_____)_____Cell Phone No. (_____)_____

Insured's Employer_____ Employer Insurance Plan:_____Yes_____No

Secondary Insurance *(Insurance that pays second)* _____

Address_____ City____State_____Zip Code____

Group name/#:_____Policy Dates: From_____To_____Insurance ID #_____

Secondary Insurance Subscriber/Policyholder Information:

_____

Last Name First Name (M.I.)

Address _____

City_____ State _____ Zip Code_____

Relationship of Policy Holder to Patient_____Sex:_____M _____F

Date of Birth_____ Social Sec. #_____

Home Phone No. (_____)_____Cell Phone No. (_____)_____

Insured's Employer_____Employer Insurance Plan:_____Yes_____No