GENERAL INTERNAL MEDICINE GROUP, INC.

Office Use Only

Patient # _____

Physician _____

PATIENT REGISTRATION **New Patient:** ☐ **YES** ☐ **NO**

PATIENT NAME Last	First	Initial		PATIENT'S SOCIAL SECURITY NO.	
PATIENT ADDRESS Street	Apt			☐ Male ☐ Female DOB mo_____ day_____ year_____	
City	State	Zip		MARITAL STATUS ☐ single ☐ married ☐ widow(er) ☐ divorced ☐ partner	
Home Phone				Email	
Cell Phone				Work Phone	
PREFERRED METHOD OF CONTACT ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Mail					
EMPLOYER NAME/ADDRESS		CITY	STATE	ZIP	
IN CASE OF EMERGENCY NOTIFY:		RELATIONSHIP	TELEPHONE NO.		
PRIMARY CARE PHYSICIAN:				REFERRING PHYSICIAN:	
ADDRESS:				ADDRESS:	
CITY:	STATE:	ZIP:		CITY:	STATE: ZIP:
PHONE ( )				PHONE ( )	
HOW DID YOU HEAR ABOUT THIS PRACTICE? ☐ ANOTHER PHYSICIAN ☐ HEALTH PLAN DIRECTORY ☐ FRIEND/COWORKER ☐ ANOTHER PATIENT ☐ OTHER (SPECIFY)					

PLEASE PRESENT YOUR INSURANCE CARD(S) TO RECEPTIONIST. **IS THIS INJURY/ILLNESS WORK RELATED?** ☐ **YES** ☐ **NO**

PRIMARY INSURANCE CO.		GROUP#
POLICY HOLDER NAME	DOB OF POLICYHOLDER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent
POLICY #	POLICYHOLDER SS#	
SECONDARY INSURANCE CO.		GROUP#
POLICY HOLDER NAME	DOB OF POLICYHOLDER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent
POLICY #	POLICYHOLDER SS#	

FEDERAL GOVERNMENT REGULATIONS REQUIRE US TO COLLECT THE INFORMATION BELOW:

Race:	☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ More Than One Race ☐ Native Hawaiian	☐ Other Pacific Islander ☐ Refused to Report / Unreported ☐ Undefined ☐ White
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Other Pacific Islander ☐ Undefined
Language	IMPAIRMENT ☐ Sight ☐ Hearing ☐ Physical ☐ Other_____	

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

Signature _____ Print Name _____ Date _____