Ageless Men's Health V1.2

PATIENT REGISTRATION FORM

Date:_____ Chart Number:_____

PATIENT INFORMATION

How did you hear about our clinic? _____Email Address_____

Last Name_____ First Name_____ M Initial_____

Address_____

City/St/Zip_____ Date of Birth _____

Marital Status (circle) Single Partnered Married Separated Divorced Widowed

Age _____ Height_____Weight _____ SS #_____

Home Phone_____ Cell _____

Employer_____ Work Phone _____

Work Address_____ City/State/Zip _____

Employment status: (circle) Full-time Part-time Retired Self-employed Active Military None

How would you like to be contacted for lab results & appointment reminders? (circle) Cell Ph. Home Ph. Text E-mail Fax

Occupation: _____

EMERGENCY CONTACT

Name_____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ Insured ID#_____

Is this a Medicare Advantage or Medicare Replacement Plan? _____

Address_____ _ Group# _____

City/St/Zip _____ Phone_____

POLICY HOLDER INFORMATION (if different than yourself)

Name of Insured_____ **Insured Date of Birth** _____

Patient Relationship to Insured _____

If Insurance is through a Group Health Plan, List Name of Company/Employer: _____

Is Insurance is through a Group Health Plan, are you currently employed by that Company? Y / N

Do you have Secondary Insurance? Y / N

SECONDARY INSURANCE_____ Insured ID#_____

Is your Secondary Insurance Medicare, or a Medicare Replacement/Advantage Plan? _____

Address_____ Group# _____

City/St/Zip _____ Phone_____

POLICY HOLDER INFORMATION (if different than yourself)

Policy Owner_____ **Insured Date of Birth** _____

Patient Relationship to Policy Owner _____