MIDWESTERN UNIVERSITY CLINIC

PATIENT REGISTRATION FORM

Please Print

Please check one: ☐ NEW PATIENT ☐ PATIENT UPDATE

PATIENT INFORMATION

Patient Name: ______________________
(Last) (First) (MI)

Gender: (circle) M F Date of Birth: __________

Marital Status: M D S W Last four (4) of SSN: ______

Address: ______________________

City, State, Zip: ______________________

Please check the box next to the best phone # to reach you during the day.

Home phone #: ______________________ ☐

Cell phone #: ______________________ ☐

Work phone #: ______________________ ☐

Email address: ______________________

PARENT/GUARDIAN (if patient is a minor)

1) Name: ______________________
(Last) (First) (M)

Gender: (circle) M F Date of Birth: __________

Relationship to Patient: __________

Cell Phone #: __________

2) Name: ______________________
(Last) (First) (M)

Gender: (circle) M F Date of Birth: __________

Relationship to Patient: __________

Cell Phone #: __________

Emergency Contact: ______________________

Phone: ______________________

How did you hear about us: ______________________

Relationship: ______________________

Referred by: ______________________

The Federal Government requires we obtain the following information for reporting purposes only.
People will not be identified by the following information.

1. What is your RACE? A. White B. Asian C. African American D. American Indian/Alaskan Native E. Native Hawaiian F. Pacific Islander G. More than one race
2. What is your ETHNICITY? A. Hispanic/Latino B. Non-Hispanic/Non-Latino
3. What is your primary language? A. English B. Spanish C. American Sign Language D. Other

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Primary Insurance

Insurance Company: ______________________

ID #: ______________________

Group #: ______________________

Effective Date: ______________________

Policy Holder: ______________________

Policy Holder DOB: __________ Gender: M F

Relationship to Patient: ______________________

Secondary Insurance

Insurance Company: ______________________

ID #: ______________________

Group #: ______________________

Effective Date: ______________________

Policy Holder: ______________________

Policy Holder DOB: __________ Gender: M F

Relationship to Patient: ______________________

Primary Care Physician: ______________________ Phone #: __________

Primary Pharmacy: ______________________ Phone #: __________

SIGNED: ______________________ DATE: __________