

Bear Internal Medicine and Pediatrics, PA  
**PATIENT REGISTRATION - Please complete all areas.**

How would you like us to address you? (Mr/Mrs/Ms/First name/Nickname) \_\_\_\_\_

<u>PATIENT INFORMATION</u>	
Name(First,Middle,Last)_____	M/F
SS# _____	Date of birth _____
Mailing Address _____	
Home Address _____	
Home phone _____	Cell/Day/Pager _____
Marital status _____	Spouse's name _____
Patient Occupation _____	
Employer name/address _____	
Employer phone _____	Is visit for job-related injury or an auto accident? Y/N
<b>How did you hear about us?</b> _____	

<u>Guarantor/Insurance Information</u>	
First/M/Last name _____	
SS# _____	M/F
Date of birth _____	
Address _____	
_____	
Phone _____	
Relationship to patient _____	
Ins Carrier _____	
Ins address _____	
Policy # _____	
Group # _____	
Effective Date _____	
Employer name _____	
Emp address _____	
Emp phone _____	
Is there a secondary insurance? Y/N	
<u>If patient is a minor</u>	
Do both parents live in the same home? _____	
Mother _____	
Contact info _____	
_____	
Father _____	
Contact info _____	
_____	
May the office share medical information with either parent? Y/N	

<u>Emergency Contacts</u>	
Name _____	
Relationship _____	
Address _____	
_____	
Phone _____	
Name _____	
Relationship _____	
Address _____	
_____	
Phone _____	
<u>Medical History</u>	
Prior healthcare providers City/State	
Or hospitals	
_____	
_____	
_____	
Preferred Pharmacy/phone number	
_____	
_____	

My signature below attests that I have completed the above information in good faith to the best of my knowledge. I will inform this office of any significant changes within a reasonable period of time.

Sign \_\_\_\_\_  
Print name \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Date \_\_\_\_\_

Please inform us if anyone else may be bringing minors to office visits instead of parents. **Also request a release of medical records if you have prior records to be transferred to this office.**