Bear Internal Medicine and Pediatrics, PA

Patient Registration – Please fill out completely

First name: _____ Middle initial: _____

Last name: _____ Date of birth: _____

Preferred name/Nickname: _____ Race: _____Ethnicity: _____

Birth sex: Male / Female Preferred pronoun: _____ Marital status: _____

Mailing address: _____

Contact phone numbers: Cell: _____ Home/Work: _____

Email address if registering for the patient portal: _____

Occupation: _____ Employer: _____

Primary insurance company: _____ Name of policy holder: _____

Previous primary care provider(s) (Name/PH#): _____

_____

Preferred pharmacy (name/address): _____

Emergency contacts:

#1 Name: _____ Relationship: _____

Phone Number: _____

#2 Name: _____ Relationship: _____

Phone number: _____

If patient is a minor/under 18 years of age:

Do both parents live in the same household: Yes / No

Parent #1 (name/PH#): _____

Parent #2 (name/PH#): _____

I agree to allow the office to share medical information with either parent: Yes / No

How did you hear about us? _____

My signature below attests that I have completed the above information in good faith to the best of my knowledge. I will inform the office of any significant changes within 60 days.

Signature: _____

Name: _____

Relationship to patient: _____ Today's Date: _____