Bear Internal Medicine and Pediatrics, PA

PATIENT REGISTRATION - Please complete all areas.

How would you like us to address the patient? ________________________________

PATIENT INFORMATION

Name (First/Middle/Last) ________________________________
Date of birth ____________________ Male / Female
Mailing Address________________________________
Home Address________________________________
Home phone____________________ Cell phone ____________________
Marital status______________ Spouse's name____________________
Patient Occupation________________________________
Employer name________________________________
Is visit for job-related injury or an auto accident? Y/N
Email address if registering for the Patient Portal ____________________
How did you hear about us? ________________________________

Guarantor/Insurance Information

First/M/Last name____________________
Date of birth ____________________
Address____________________
____
Phone____________________
Relationship to patient____________________
Ins Carrier____________________
Policy # ____________________
Group # ____________________
Effective Date____________________
Employer name____________________
Is there a secondary insurance? Y/N

If patient is a minor

Do both parents live in the same home? _______
Parent #1____________________
Contact info ____________________
____
Parent #2____________________
Contact info ____________________
____
May the office share medical information with either parent? Y/N

Please inform us if anyone else may be bringing minors to office visits instead of parents.

Emergency Contacts

Name/Relationship____________________
Address ____________________
____
Phone ____________________

Name/Relationship____________________
Address ____________________
____
Phone ____________________

Medical History

Prior healthcare providers Or hospitals City/State
____
____

Preferred Pharmacy/location
____
____

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 60 days of change.

Sign ____________________
Print name ____________________
Relationship to patient____________________
Date____________________