MERIDIAN PRIMARY CARE PATIENT REGISTRATION

NAME: _____DOB: ____/_____/_____TODAY'S DATE:____/____/_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____ WORK PHONE: (_____)_____

SOCIAL SECURITY NUMBER:_____-_____-_____ GENDER: _____Male _____Female _____TG

PRIMARY LANGUAGE:_____ ETHNICITY: _____ Hispanic _____ Non-Hispanic

RACE: (select one) _____American Indian / Native American _____Asian _____Black / African American
_____ Native Hawaiian _____Pacific Islander _____White / Caucasian
Bi-racial / Multi-racial: _____ OTHER: _____

MARITAL STATUS: _____ Single _____ Married _____Separated _____Divorced _____Widowed

IF CHILD, LEGAL CUSTODY HOLDER(S): (Please bring documents) _____

RELATIONSHIP?: _____ JOINT CUSTODY: _____Yes _____No

NAME POWER OF ATTORNEY (Please bring documents): _____

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PATIENT EMPLOYER: _____ OCCUPATION:_____

EMPLOYER ADDRESS: _____ CITY: _____STATE:_____ZIP:_____

EMPLOYER PHONE: (_____) _____IF RETIRED, FROM WHERE?: _____WHEN?:_____

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PRIMARY INSURANCE:_____**COPAY AMOUNT: $_____**

MEMBER NUMBER:_____GROUP NUMBER: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP:_____

SOCIAL SECURITY # OF POLICY HOLDER: _____- _____-_____ POLICY HOLDER DATE OF BIRTH: _____/_____/_____

POLICY HOLDER'S EMPLOYER:_____ EMPLOYER ADDRESS:_____

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SECONDARY INSURANCE:_____

MEMBER NUMBER:_____GROUP NUMBER: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP:_____

SOCIAL SECURITY # OF POLICY HOLDER: _____- _____-_____ POLICY HOLDER DATE OF BIRTH: _____/_____/_____

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PLEASE LIST YOUR HOUSEHOLD MEMBERS:

LAST NAME, FIRST NAME:	GENDER:	RELATIONSHIP:	DOB:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE NUMBER: (_____) _____ - _____