

Family Care Specialists (FCS) Medical Group Patient Registration

PATIENT INFORMATION

Last Name		First Name		Initial		Previous Name (Maiden)	
Street Address				City		State Zip	
Street Address				City		State Zip	
Home Telephone ()			Employer Telephone ()			Cellular Telephone ()	
Birth Date		Age		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> P	
E-Mail Address				Occupation		Social Security Number	
Employer Name			Date Employment Began			Preferred Language Race	
Employer's Street Address				City		State Zip	
Referred by							

SPOUSE / GUARDIAN INFORMATION

Last Name		First Name		Initial		Relationship to Patient		Birth Date		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address				City		State		Zip			
Home Telephone ()			Employer Telephone ()			Cellular Telephone ()					
Driver License Number			Social Security Number			Birth Date					
Employer Name				Date Employment Began			Occupation				
Employer's Street Address				City		State		Zip			

INSURANCE INFORMATION

Medicare Number		Part B <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective Date		Medi-Cal Number	
Policy / ID Number			Group / Local Number		Coverage / Plan Number		
Insurance Company Name – Primary				Insured / Subscriber		Patient Relationship to Insured	
Insured / Subscriber:			Birth Date		Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Policy / ID Number			Group / Local Number		Coverage / Plan Number		
Insurance Company Name – Secondary				Insured / Subscriber		Patient Relationship to Insured	
Street Address			City		State Zip		Telephone ()

NEAREST RELATIVE / FRIEND NOT LIVING WITH YOU?

Last Name		First Name		Initial		Relationship to Insured	
Telephone Number in case of an emergency:							
Assignment: I authorize payment of medical benefits to the under Signed physician or supplier for service described.							
Lifetime Medicare Authorization				<input type="checkbox"/> Yes <input type="checkbox"/> No		Date:	
Have you ever been here before:				<input type="checkbox"/> Yes <input type="checkbox"/> No		When?	

Patient Signature

Date