University Internal Medicine, Inc.
Patient Registration Form

Last 4 digits of Patient's Social Security Number _____

Patient's Name _____
(First) (Middle Initial) (Last)

☐ Male ☐ Female Date of Birth ___/ ___/ ___ Marital Status _____

Address _____
(Street) (City, State, Zip Code)

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Phone (circle one) Home/Cell/Work

Email Address_____

Emergency Contact Person _____ **Phone #** _____

Employed ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐

Employment Information

Patient's Employer _____

Employer's Address _____ Phone # _____

Medical Insurance Coverage, Please Provide Copy of Insurance Card:

Primary Insurance Carrier _____

Policy # _____ Group # _____

Subscriber's Name _____ Date of Birth _____/ _____/ _____

Subscriber's Employer _____

Relationship to Patient _____

Secondary Insurance Carrier _____

Policy # _____ Group # _____

Subscriber's Name _____ Date of Birth _____/ _____/ _____

Subscriber's Employer _____

Relationship to Patient _____

We want to make sure that we identify and address each patient's needs and ensure that all patients get the best care possible.

Race:	**Ethnicity:**
Which of the following best describes your race? (Select all that apply) _____ American Indian or Alaska Native _____ Asian _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _____ White _____ Refused _____ Unknown	Which of the following best describes your ethnicity? _____ Latino/Hispanic _____ Not Hispanic or Latino _____ Other _____ Refused
Language: Which language do you prefer to use to talk with your Health Care team? _____	**Sex Assigned at Birth:** _____ Female _____ Male _____ Unknown
Gender Identity: _____ Male _____ Female _____ Transgender Male/Female-to-Male _____ Transgender Female/Male-to-Female _____ Genderqueer; Neither Exclusively Male nor Female _____ Declined _____ Other	**Sexual Orientation:** _____ Straight _____ Gay _____ Lesbian _____ Bisexual _____ Other _____ Unknown _____ Declined

I authorize all Health Care Providers including insurance companies, HMO's, hospital and medical service corporations to pay directly to University Internal Medicine, Inc. all benefits due under said policy by reason of services rendered. I also authorize the release of any medical information necessary to process claims for the professional services rendered to me. I understand that I am ***financially responsible to University Internal Medicine, Inc. for charges not covered*** by this authorization and do hereby agree upon receipt of bill to pay directly in full.

Print Name: _____

Signature: _____ Date: _____/ _____/ _____

Relationship (if signed by family member) _____