PATIENT REGISTRATION

Jefferson City Medical Group

Please Print *(Legal)*

Patient Name: (First) (Middle) (Last) (Nickname)				
Physical Address:				
City, State, Zip:				
Billing Address:				
City, State, Zip:				
Home Phone: - -	Cell Phone: - -	Emergency Contact Person:	Relationship:	Emergency Phone: - -
Age:	Date of Birth: / /	Sex: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other	
Social Security Number: - -	Ethnicity: ☐ Non Hispanic ☐ Hispanic ☐ Unknown ☐ Decline			
Patient Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other ☐ Unknown ☐ Decline				
Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Finnish ☐ Czech ☐ Italian ☐ Other				
Email Address:		Pharmacy:		
Patient's Employer:		Occupation:		
Address:		Work Phone: - - Ext:		
Referring Physician:		Primary Physician:		
Spouse:	Social Security Number: - -	Birth Date: / /		
Spouse's Employer:		Phone: - -		
Address:				
Nearest Relative: (Not living with you)	Relationship:	Phone: - -		

Person Responsible for Payment
(only complete if different than patient)

Name:		
Address:		
Home Phone Number: - -	How Related:	
Employer:	Work Phone Number: - -	
Occupation:	Social Security Number: - -	

Insurance Information
Must present Insurance card.

Insurance Company Name:			
Policy Number:	Group Number:	Subscriber Name:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Social Security Number:	- -	Birth Date: / /	
Secondary Insurance Company: (If applicable)			
Policy Number:	Group Number:	Subscriber Name:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Social Security Number: - -		Birth Date: / /	

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR:

✓ Date: / /