



**REGISTRATION**  
Please Print

Date \_\_\_\_\_ Is this your first visit to a PacMed Clinic? Y \_\_\_\_\_ N \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ SSN \_\_\_\_\_

AKA (Nickname) \_\_\_\_\_ Birth Name \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ Sex M F Married or Single

Permanent Address:  
Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip Code \_\_\_\_\_

Mailing Address:  
Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Message/Alternate Phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Who is your primary medical care provider (PCP)? Name \_\_\_\_\_

Address/Clinic \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ DOB: \_\_\_\_\_

Permanent Address:  
Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_



Patient Name:

DOB:

MRN:

Clinic Location:

**PATIENT EMERGENCY CONTACT**

Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (     ) \_\_\_\_\_ Work Phone (     ) \_\_\_\_\_

Message/Alternate Phone/Cell (     ) \_\_\_\_\_

**INSURANCE INFORMATION**

Is your condition related to employment (current or previous employer)? Y N

Is your condition related to other accident? Y N

Are you covered under any of these programs?

Medicare Y N     Medicaid Y N     CHAMPUS Y N     CHAMPVA Y N     USFHP Y N     Worker's Compensation Y N

If yes, Claim Number: \_\_\_\_\_

**Do you have medical insurance?** Y N

**If yes:**

Name of Primary Insurance Carrier \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Employer \_\_\_\_\_

Name of Secondary Insurance Carrier \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Employer \_\_\_\_\_

**PLEASE NOTE, PACMED CLINICS DO NOT ACCEPT LIENS OR BILL FOR 3RD PARTY MOTOR VEHICLE OR OTHER ACCIDENTS.**

**I CERTIFY THAT THE INFORMATION I HAVE GIVEN ABOVE IS TRUE AND CORRECT:**

Patient/Parent or other authorized representative signature \_\_\_\_\_

Date \_\_\_\_\_