Patient Registration Form
Richmond Family Practice

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ________________________ (First) ____________ (MI) _____ Previous Name ________________________

Address Line 1 ____

City, State ________________________________ ZIP___________ Pharmacy______________Pharmacy Phone_______________

Home Phone ______________________ Cell No. _____________________ Work Phone _________________Ext. ____________

Primary Care Provider (PCP) __________________________________ Referring Provider ___________________________________

Rendering Provider Name (this practice) ________________________________ E-Mail Address:_____________________________

Date of Birth MM _______/DD _________/YYYY _____________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ___________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ______-_______-_________ Employer Name ____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ______________________________________ First Name ______________________________

Phone Number ____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____ ☐ Guardian

Address Line 1 ____

City, State ________________________________ ZIP_________________

Home Phone ________________________________ Work Phone ___________________________ Ext. __________________

Referring Provider Name ____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ____________________________ (First) ___________________________ (MI) ____________

Guarantor Account Number ____________________________ Date of Birth MM _________/DD _________/YYYY ____________

Social Security Number _______-______-________ Telephone ______________________

E -Mail Address _______________________________________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State ________________________________ ZIP ___________________

Employer____ Employer Phone Number_____________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (_______)_________________

Name of Insured____ Patient Relationship to Insured_____________________

Subscriber ID (Policy Number)___________________ Group ID__________________ Copay Amount____________________

Effective Date_____________________ Termination Date_______________ Date of Birth MM _______/DD _______/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (_______)_________________

Name of Insured____ Patient Relationship to Insured_____________________

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Subscriber ID (Policy Number)____________________ Group ID___________________ Copay Amount_____________________

Effective Date_________________________ Termination Date_________________Date of Birth MM _______/DD ______/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***__________________

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