EMERGENCY
PHYSICIANS MEDICAL CENTER

Patient Registration

Have you been here before?	Yes No
Last Name	
First Name	
Date of Birth	
Gender	Female Male
Address	
Home Phone	
Cell Phone	
Work Phone	
E-Mail	
Reason for visit today	
Do you have a history of:	Hypertension Diabetes Asthma/COPD Other _____
Current Medications	
Allergies	
Do you smoke?	Yes No
Do you drink?	Yes No
Do you have a primary physician?	Yes No
Primary physician name	

Please continue on other side.

Patient Registration – page 2

Do you have insurance?	Yes No
Insurance Company Name	
Policy holder's name	
Policy holder's date of birth	
Insurance Group ID number	
Insurance number	
Employer	
Emergency contact information	
How did you hear about Emergency Physicians Medical Center?	Family or friend Website Yellow Pages Newspaper Article Other _____

Please return this to the Front Desk when completed with your

- ***Drivers License and***
- ***Insurance Card.***

Thank you.