Health First
Medical Group

Patient Registration

Patient Information					
Patient Name (First, Middle Initial, Last)		Street Address		City, State	Zip Code
Home Phone	Mobile Phone		Work Phone		
Emergency Contact's Name		Emergency Contact's Phone Number		Emergency Contact's Relationship	
Patient's Email Address		Patient's Date of Birth		Sex	Marital Status
Race	Ethnicity	Primary Language	Social Security Number	Employer	

Payment Responsible Party Information (if different than above)				
Patient Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Sex	Marital Status
Mailing Address	Secondary Billing Address (if applicable)			
City, State, Zip Code	Home Phone			
Cell Phone	Pager Number			
Relationship to Patient				

Primary Insurance		
Name of Insurance Company	Policy Number	
Name of Insured	Group Number	
Mailing Address of Insurance Company	Copay Amount $	
City, State, Zip Code	Deductible $	
Relationship to Patient	Effective Date	Expiration Date

Secondary Insurance (if applicable)		
Name of Insurance Company	Policy Number	
Name of Insured	Group Number	
Mailing Address of Insurance Company	Copay Amount $	
City, State, Zip Code	Deductible $	
Relationship to Patient	Effective Date	Expiration Date

Referral Information	
Name of Referring Physician	City, State

How did you hear about us (if not referred by another physician)?

1. Yellow Pages 2. Media Advertisement 3. Internet 4. Insurance Referral 5. Personal Referral 6. Other: _____

_____
Patient/Responsible Party (print name)

_____ _____
Signature of Patient/Responsible Party **Date**

Health First agrees never to sell your information. By submitting your email address you expressly agree to receive promotional information from Health First facilities, subcontractors and their affiliates regarding information, events, promotions, specials and patient satisfaction surveys. You also understand that you have the right to "opt out" at any time through request in a reply to the email.

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