

**Southern Illinois Family Medicine**

PATIENT REGISTRATION - P1

PLEASE PRINT Today's Date \_\_\_\_\_ SSN \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ Marital Status \_\_\_\_\_

HOME# \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_

\*Email \_\_\_\_\_ Pharmacy \_\_\_\_\_ City \_\_\_\_\_

Do you smoke yes \_\_\_ or \_\_\_ no Full-time Student \_\_\_ Part-time \_\_\_ Not a Student \_\_\_\_\_

\*Can we mail information to the above address about appointment and/or test results YES\_\_ NO \_\_

PHONE # WHERE DR. CAN REACH YOU \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT

ADDRESS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PARENT GUARDIAN NAME (for pediatric patients) \_\_\_\_\_

-----GUARANTOR INFORMATION-----

PERSON RESPONSIBLE FOR INSURANT (guarantor) \_\_\_\_\_

ADDRESS (if different from above) \_\_\_\_\_

RESPONSIBLE PARTY PHONE \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP PATIENT \_\_\_\_\_ EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I hereby consent to the medical treatment as ordered by my medical provider or their designees. I authorize the release of medical information to process payment on my account. I authorize payment of medical benefits directly to the provider of service. I understand I will be Responsible for the unpaid balance of my account. I certify that the information is correct.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

