Intown Primary Care, P.C.
Patient Registration
(Please Print)

Date_____/_____/_____

Name_____
First Middle Last

Date of Birth_____/_____/_____ Social Security Number_____

Sex: Female_____ Male_____ Other_____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____

Race: American Indian/Alaska Native_____ Asian_____ Black or African American_____
Native Hawaiian or Other Pacific Islander_____ White_____

Preferred Language: English_____ Other_____ please specify _____

Address_____

_____
City State Zip

____ Home Phone_____ Work Phone_____

____Cell Phone_____ ***please place a check by your preferred method of contact**

____Email Address_____

Marital Status: Single_____ Married_____ Partnered_____ Divorced_____ Widowed_____

Sexual Orientation: Heterosexual_____ Homosexual_____ Bisexual_____ Other_____

Employer_____

Occupation_____

Significant Other_____

Emergency Contact_____
Name Relationship

Emergency Contact_____
Address

_____
City State Zip Phone Number

Insurance Information

Primary Carrier_____

Policy Number_____

Effective Date_____/_____/_____ Copay Amount_____

Carrier Address_____

_____
City State Zip

Phone Number_____

Secondary Carrier_____

Policy Number_____

Effective Date_____/_____/_____ Copay Amount_____

Carrier Address_____

_____
City State Zip

Phone Number_____

I authorize the release of any medical or other information necessary to process this claim, including information related to HIV/AIDS, mental health, and substance abuse. I also request payment of government benefits whether to myself or to the party who accepts assignment. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered.

_____ _____
Responsible Party Signature Date

Intown Primary Care, P.C.
Patient Registration
(Please Print)

Date_____

Name_____
First Middle Last

Female_____ Male_____ Other_____ Date of Birth_____ Current Age_____

Occupation_____

Marital Status: Single_____ Married_____ Partnered_____ Divorced_____ Widowed_____

Please list all know drug allergies:_____

Past Medical History

Please check all past or current medicals conditions:

_____Allergies
_____Anemia
_____Anxiety
_____Arthritis
_____DVT
_____Asthma
_____Alcohol Abuse
_____Breast Cancer
_____Colon Cancer
_____Diabetes Type 1 / 2
_____Depression
_____Bipolar Disorder
_____Drug Abuse
_____Eating Disorder
_____Enlarged Prostate

____Kidney Stones
____Genital Warts
____Gout
____Coronary Artery Disease
____COPD
____Heartburn/GERD
____Hepatitis A/B/C (circle)
____Herpes oral/genital (circle)
____High Cholesterol
____HIV/AIDS
____Hypertension
____Seizures
____Hyperthyroid
____Hypothyroid
____Insomnia

____Chronic sinusitis
____Low Back Pain
____Hemorrhoids
____Obesity
____Erectile Dysfunction
____Valvular Disorders
____Prostate Cancer
____Pneumonia
____Irritable Bowel Syndrome
____Fibromyalgia
____Syphillis
____Sleep Apnea
____Stroke
____Tuberculosis
____Headache

Other:_____

Please list all past
Surgeries/hospitalizations:_____

_____

Please list current
Medicines/supplements:_____

_____