Boones Creek Medical

Patient Registration Form

****

Demographics

Patient Name: _____ Today's Date _____ / _____ / _____

Date of Birth _____ / _____ / _____ Social Security Number: _____

Address: _____ Home Phone _____

City: _____ State: _____ Zip: _____ Cell Phone _____

Email Address: _____

Gender: MALE FEMALE TRANSGENDER Race/Ethnicity: _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

****

Emergency Contact Information

Emergency Contact Name: _____ Phone: _____

Relationship: _____

****

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name: _____ Subscriber Name_____

Date of Birth: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Relationship to Patient: _____ Relationship to Patient: _____

****

Preferences

Is it ok if we share you medical record with your other providers such as specialists for coordination of care? Y N

Is it ok if we receive prescription information from your pharmacy? Y N

Is it ok to receive automated calls from our EMR system for appointment reminders, normal lab results, etc.? Y N

Is it ok to receive automated texts from our EMR system for appointment reminders, normal lab results, etc.? Y N

Is it ok to leave personal health information (such as lab results) on your voicemail? Y N

What is the name and location of your preferred pharmacy? _____