Stonebrook Family Medicine
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PATIENT REGISTRATION

Date: _____ **Social Security** #:_____

Patient: _____ **DOB**: ____/____/_____

Address: _____ Home Phone: _____

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

Employer: _____ Work Phone: _____

Race **(Optional)**: Decline____ White_____ Asian____ Black/African American____ Other_____

Email: (For Patient Portal Use **ONLY**) _____

Preferred Reminder: Home Phone_____ Cell Phone_____ Patient Portal_____

Spouse: _____ DOB: ___/___/___ SS#: _____

Spouse's Employer: _____ Spouse Work Phone: _____

Spouse's Cell Phone:_____

Mother (if a minor): _____ *DOB:* ___/___/___ *SS#:* _____

Employer: _____ *Work /Cell Phone:* _____

Father (if a minor): _____ *DOB:* ___/___/___ *SS#:* _____

Employer: _____ *Work Phone:* _____

Address of Policy Holder/Guarontor's: _____

City: _____ *State:* _____ *Zip:* _____ *Home/Cell Phone:* _____

Children

Name: _____ Sex: M / F DOB: ___/___/___ SS#: _____

Name: _____ Sex: M / F DOB: ___/___/___ SS#: _____

Name: _____ Sex: M / F DOB: ___/___/___ SS#:_____

Emergency Contact Person: _____Relation_____Phone: _____

Insurance Information

Policy Holder/Guarontor's Name: _____ Relation to policy holder_____

Policy Holder's Social Security #:_____ *Policy Holder***'s** DOB: ____/____/____

We file your insurance as a courtesy. It is to your advantage to become familiar with your health insurance benefits.

All Persons Covered Under This Policy:

_____ _____

How did you hear about us? _____