DR. J EXPRESS CARE PATIENT REGISTRATION

Patient Information

Patient Full Name:

☐ New Patient ☐ Existing Patient

Reason for Visit:

Date of Birth: Gender: □ Male □ Female

Social Security #: Ethnicity/Race:

Local Address: Apt #:

City: State: Zip:

Primary Phone #: □ Home □ Cell □ Work

Secondary Phone # : □ Home □ Cell □ Work

Email Address: By providing your email address, you consent to our Email Privacy Policy

How did you hear about us?

□ Location □ Customer Service □ Email □ Facility Signage
□ Family/Friend/Word of Mouth □ Internet/Online Search □ Print Advertising
□ Radio □ Phone Book/Yellow Pages
□ School/Daycare: _____ □ Employer: _____
□ Community Event: _____ □ Hotel: _____
□ Physician Referral: _____ □ Pharmacy: _____
□ Apartment Complex: _____ □ Insurance: _____

Marital Status: □ Child □ Single □ Married □ Divorced □ Widowed □ Separated

Spouse's Full Name:

Permanent Address (other than local):

City: State: Zip:

Primary Care Physician:

Employer:

Thank you for choosing DR J Express Care. Your satisfaction is important to us! Please leave your email address in the space provided and we will send you a survey about your visit today.

Insurance Subscriber Information

Complete Only if NOT the Patient

Insured Subscriber Full Name:

Subscriber's Date of Birth:

Subscriber's Social Security #:

Subscriber's Relationship to Patient:

Subscriber's Permanent Address: Apt #:

City: State: Zip:

Subscriber's Primary Phone #: □ Home □ Cell □ Work

Subscriber's Secondary Phone #: □ Home □ Cell □ Work

Subscriber's Employer:

Complete Insurance Details

Insurance Company:

Type: □ HMO / PPO □ Medicare □ Medicaid/AHCCCS □ Tricare □ Other

ID / Policy #: Group #:

Copay/Coins/Ded Amount: Effective Date:

Secondary Insurance? □ Yes □ No Name:

Parent/ Legal Guardian of Minor or Incapacitated Adult Only

Full Name: Date of Birth:

Relationship: Contact #:

Signature

Patient's Name: Date:

Signature: