Covenant Medical Group

Date: _____

Patient Information:

Primary Care Provider:	Provider for Today's Visit:	SSN#:
Name (Last, First, Middle):		Birth Sex: How do you identify, if different than above?
Birth Date:	Age:	Preferred Language:
Veteran (Circle Answer): Yes or No		Ethnicity (Circle Answer): Hispanic or Non-Hispanic
Race (Circle Answer): African American, Alaskan Native, Asian, Hawaiian, Native American Indian, White		Marital Status (Circle Answer): Single, Married, Widowed, Divorced, Legally Separated, Life Partner, Unknown
Mailing Address:		City, State, Zip:
Home Phone:	Cell Phone: Work Phone:	Email Address:
Emergency Contact Name: Relationship to Patient:		Emergency Contact Numbers: Home Phone: Work Phone: Cell Phone:
Referring Physician:		Referring Physician Contact:

If you are a new patient, how did you learn about our office (Circle answer): Direct Mail Family/Friend Internet Ad/Search Newspaper Ad Referral Social Media Other:

If patient is a minor, please fill out this portion:

Parent or Guardian's Name:	Home Phone: Work Phone:	Cell Phone:
Other Parent:	Home Phone: Work Phone:	Cell Phone:

Responsible Party Information (if different from above):

Name (Last, First, Middle):	SSN#:	Birthdate:	Sex:
Address:	City, State, Zip:		
Home Phone:	Cell Phone:	Work Phone:	Relationship to patient:

Primary Insurance (make copies of cards if available, if not, fill in the information below):

Name of Insurance Company:	Name of Insured:	Address of Insured (if different than address above):	
Insured's Birthdate:	Insured's SSN #:	Insured's Insurance ID #:	Relationship to patient:

Secondary Insurance (if applicable):

Name of Insurance Company:	Name of Insured:	Address of Insured (if different than address above):	
Insured's Birthdate:	Insured's SSN#:	Insured's Insurance ID #:	Relationship to patient:

Workers Compensation:

Are you here for workers compensation (Circle): Yes No Date:

Accident (circle answer):

Auto Work Other	Date of Accident:

Registration Staff Signature: _____ Date: _____ Time: _____