

Carolina Internal Medicine Associates – Patient Registration Form

PATIENT INFORMATION

Name: _____ Birth Sex: Female Male DOB: _____

Mailing Address: _____ Apt/Suite # _____

Phone (H): _____ (W): _____ (C): _____

City: _____ State: _____ ZIP Code: _____ SS# _____

E-Mail Address: _____

Preferred Contact Method: Home Phone Work Phone Cell Phone Mail

By providing a phone number, mobile phone number, or email address above, I authorize Carolina Internal Medicine Associates to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

EMERGENCY CONTACT

Name: _____ Home/Cell Number: _____

Relationship to Patient: _____

Preferred Language:

- English
- Spanish
- Russian
- American Sign Language
- Something else: _____

Ethnicity (select all that apply):

- Mexican/Mexican American/Chicano
- Puerto Rican
- Cuban
- Hispanic/Latino/Spanish
- Non-Hispanic/Latino/Spanish
- Choose not to disclose.

Marital Status

- Single
- Partnered
- Married
- Separated
- Divorced
- Widow

Race:

- American Indian/Alaskan Native
- Asian
- Black/African American
- Native Hawaiian/Other Pacific
- White
- Other (please specify) _____
- Prefer not to specify.

Sexual Orientation:

- Heterosexual/Straight
- Gay/Lesbian
- Bisexual
- Other (please specify)
- Prefer not to specify.

Gender Identity

- Male
- Female
- Transgender Male
- Transgender Female
- Something else: _____
- Choose not to disclose.

Preferred Pronouns

- She/Her
- He/Him
- They/Them

MEDICAL INFORMATION

Special Hearing Needs: _____ Special Vision Needs: _____

Needs Wheelchair: Yes No Speech Impaired: Yes No

INSURANCE INFORMATION

You are responsible for verifying with your insurance company that Carolina Internal Medicine is "In Network" with your insurance company. Are we in network with your insurance policy? Yes No

Primary Insurance Information:

Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Subscriber/Policy ID #: _____ Group #: _____ Co-Pay: _____

Policy Holder's Relationship to Patient: _____

Secondary Insurance Information

Secondary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Subscriber/Policy ID #: _____ Group #: _____ Co-Pay: _____

Policy Holder's Relationship to Patient: _____