PIONEER PHYSICIANS
WALK IN CLINIC

PATIENT REGISTRATION FORM

Patient Information		
Last Name	Middle Initial	First Name
Apt / Ste #:	Address	
Zip Code	City	State
Gender ☐ Male ☐ Female	**Title** ☐ MR ☐ MRS ☐ MS ☐ MISS ☐ DR ☐ JR ☐ SR ☐ II ☐ I	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown		
Date of Birth Date format (MM/DD/YYYY)		
SSN# (Social Security Number)	**What type of insurance does the patient have?** ☐ Commercial (PPO etc.) ☐ Medicare ☐ Medicaid ☐ Workers Comp ☐ Tricare ☐ Auto ☐ Self-Pay ☐ Other	

Please provide the contact phone numbers *PLEASE CHECK MARKED THE PREFFERED PHONE NUMBER*		**Email Address (Required)**
☐ Home Phone	( ) -	**Any Contact Note?**
☐ Work Phone:	( ) - X Ext. ( )	
☐ **Cell Phone:**	( ) -	

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Other_____		
Preferred Language ☐ English ☐ Spanish ☐ Polish ☐ Urdu ☐ Arabic ☐ Other - Please specify_____	**Patient's Race** ☐ Asian ☐ African American ☐ White ☐ Canadian/Latin American ☐ Other Race ☐ *Decline to Specify*	**Patient's Ethnicity** ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ *Decline to Specify*

Pharmacy Information, Emergency Contact, and Primary Care Physician		
Pharmacy Name:	Location	Phone ( ) -
Emergency Contact Name:	Phone Number ( ) -	Relationship to Patient:
Primary Care Physician Full Name	Location	Office Phone ( ) -

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Please Skip this Section if the responsible party is "yourself"		
Responsible Party Information		
Last Name	Middle Initial	First Name
Apt / Ste #:	Address	
Zip Code	City	State
Gender of Responsible Party? ☐ Male ☐ Female	**Responsible Party's Title?** ☐ MR ☐ MRS ☐ MS ☐ MISS ☐ DR ☐ JR ☐ SR ☐ II ☐ I	
Responsible Party Date of Birth Date Format (MM/DD/YYYY):		
Responsible Party SSN# (Social Security Number)		

Please provide the contact phone numbers *PLEASE CHECK MARKED THE PREFFERED PHONE NUMBER*		**Email Address (Required)**
☐ Home Phone	( ) -	
☐ Work Phone	( ) - X Ext. ( )	**Any Contact Note?**
☐ **Cell Phone**	( ) -	
Employer Name and City:		
Employment Status ☐ Full time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Active Military		

Insurance Information (Required)	
Primary Insurance	
Carrier	Subscriber Name (Main Policyholder Name)
Group Name	Subscriber ID
Group #	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Other_____
Secondary Insurance	
Carrier	Subscriber Name (Main Policyholder Name)
Group Name	Subscriber ID
Group #	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Other_____
Auto Accident, Work-related Injury, Self-Pay Options	
I would prefer to not use my insurance because:	

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☐ I was in an **Auto Accident** (R2 Form needs to be filled out) ☐ I have a **Work-Related Injury** (R3 Form needs to be filled out) ☐ I want to be **Self-Pay** (R4 Form needs to be filled out)

By my signature below, I hereby request and consent to medical treatment. I authorize the release of medical information as outlined in the practice of information policy I have been given. I authorize payment directly to the physician or supplier for services rendered and I recognize that I am ultimately responsible for payment of services regardless of insurance coverage or noncoverage.

Signature (Patient, Parent, or Legal guardian).	Today's Date / /

We appreciate your input, thank you!