Patient Registration Form

_____ _____
First Middle Last Social Security Number

Date of Birth: _____ Male □ Female □ Marital Status: _____

Address:_____
Street

_____
City State Zip

Home Phone: ( ) _____ Mobile Phone: ( )_____

Preferred Contact Method: Home / Mobile

Email Address: _____

Primary Care Provider: _____ Referring Provider: _____

Pharmacy: _____ Pharmacy Location: _____

Preferred Language: _____ Ethnicity: Hispanic/Latino Non Hispanic/Latino

Race: American Indian Asian Black/African American White Native Hawaiian/Pacific Islander Other

- **I DO CONSENT TO LEAVE A DETAILED MESSAGE AND/OR DISCUSSION:** I give Cynthia Rogers, M.D., P.A. and their staff permission to leave messages on, or to discuss my medical care and/or billing account with, the following:

  Person: _____ Person: _____

- **I DO NOT CONSENT TO LEAVE DETAILED MESSAGE:** I would like to be contacted personally, I do not authorize Cynthia Rogers, M.D., P.A. or any of its employees to leave messages or have discussions regarding my medical care and/or billing account with anyone other than myself.

Emergency Contact Information:
In case of Emergency, whom should we notify?_____
Relationship to Patient:_____ Phone#:( )_____

Insurance Information: Do you have health insurance? **Yes** □ **No** □

Primary Insurance Carrier:_____

Name of Insured (Guarantor):_____ Guarantor Date of Birth:_____

Secondary Insurance Carrier:_____

Name of Insured (Guarantor):_____ Guarantor Date of Birth:_____

Please give your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

Patient Signature:_____ **Date:**_____