Today's Date___/___/___

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: Last First Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single / Married / Divorced / Sep / Widow

Is this your legal name? □ YES □ NO	If not, what is your legal name?	Birthdate / /	Age	Sex □ M □ F □ T

Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )

Cell Phone Number ( )	Email (To be used for appt reminders)	Social Security
Occupation	Employer	Employer Phone Number

Employment Status: □ Full-Time □ Part-Time □ Not Employed □ Self-Employed □ Retired □ Active Military
Student Status: □ Full-Time Student □ Part-Time Student □ Not a Student

Race: □American Indian/Alaskan Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined
Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined
Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other ________________________

Pharmacy: | Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□Dr. _____________________ □ Insurance □Hospital □ Family □ Friend □ Yellow Pages □ Other _______________

Other Family Members Seen Here

PCP Name | Phone #

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: □ Another Patient □ Guarantor □ Self □ Check here if information is same as patient

Name	Address	Home Phone number ( )

Birth Date / /	Email Address

Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following?
□Workers Compensation □Occupational Medicine □Motor Vehicle Accident □Accident Date___________________________

Does the patient have healthcare coverage? □YES □NO	Insurance Name

Name of Insured	Social Security # - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy #)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other________________________

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages form the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

____ _____________________________

Patient/Guardian Signature Date

Ferris Family Medicine
Robert Megna, D.O., Davey M. Perrin, M.D., Carolyn Milligan, FNP
Chanida Kathe Supavong, D.O., John Arkusinski, D.O.
207 W. 5th Street, Ferris, Texas 75125
Phone: 972-842-3016 Fax: 972-842-3940

I, ____________________________________, hereby give full legal permission to allow Ferris Family Medical Clinic access to my complete medication and prescription drug history. In doing so I am agreeing to allow Ferris Family Medical Clinic to contact any doctor or pharmacy which may have this personal and confidential information.

Please check the appropriate box:

- ☐ Yes, I agree to the above terms.
- ☐ No, I wish for my history to not be given to the Ferris Family Medical Clinic.

Signature:________________________________ D.O.B.:____/____/____ Date:____/____/____