STUART M. HOMER MD
& ASSOCIATES

HYPERTENSION • NEPHROLOGY • INTERNAL MEDICINE

# PATIENT REGISTRATION

PATIENT NAME: *Last* _____ *First* _____ *MI* _____

ADDRESS: *Street* _____ *City* _____ *ST* _____ *Zip* _____

HOME PHONE: (  ) _____ CELL PHONE: (  ) _____

May we leave a message on home phone: Yes No May we leave a message on cell phone: Yes No

PERSONAL E-MAIL*: _____

** By providing an email address you will automatically be web enabled and enrolled in our practice patient portal.*

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SEX: ☐ Male ☐ Female DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

EMERGENCY CONTACT: _____ _____ PHONE NUMBER: (  ) _____

Full Name Relation

Who can we thank for referring you to our practice: _____

**PATIENT EMPLOYER:** _____

EMPLOYER ADDRESS: _____ PHONE NUMBER: (  ) _____

OCCUPATION: _____

EMPLOYMENT STATUS: ☐ Full-Time ☐ Part-Time ☐ Unemployeed ☐ Retired

Race**: ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Other

Ethnicity**: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____

*** Please note these questions are asked to comply with US Government Requirements.*

**PRIMARY INSURANCE:** _____

PHONE NUMBER: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

**SECONDARY INSURANCE:** _____

PHONE NUMBER: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

PRIMARY DOCTOR/REFERRING PHYSICIAN: _____

*Please provide Name and City/State*

PHARMACY: _____

*Please provide Name, Street Address, and State*

REASON FOR TODAYS VISIT: ☐ Primary Care ☐ Specialist