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: ( ) _____

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

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