COMPASS
PRIMARY CARE

Patient Registration Form

General Information (please print)

Name: _____ DOB _____ SSN_____

Primary address_____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Marital status: Single___ Married___ Partner____ Divorced ___ Widowed ____ Other____

Gender Identity: ☐ Male ☐ Female ☐ Trans male/Transman/FTM ☐ Trans female/Transwoman/MTF ☐other_____

Preferred pronouns ☐ She/Her/Hers:☐ He/Him/His ☐ They/Them/Theirs ☐ Ze/Zir/Hir ☐ Other_____

Gender on insurance card: ☐ Male ☐ Female Birth Gender ☐ Male ☐ Female

Race:_____ **Ethnicity:**_____ **Religious affiliation**:_____

Preferred contact (list preference1st, 2nd, 3rd): email _____ cell_____ home____ other_____

Emergency contact _____ Relationship _____ Phone _____

Pharmacy name _____ Phone _____ Fax _____

Patient Message Consent for Appointments

It is our policy to notify you to **confirm appointments**. This is to acknowledge that you authorize us to:

- Leave message by E-mail _____ YES _____ NO_____ (initial)
- Leave a message on voice mail/machine/cell YES _____ NO _____ (initial)
- Leave a text message YES _____ NO _____ (initial)

Sharing of Medical Information

I give the physician and office staff of Compass Primary Care permission to **discuss my medical condition** with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Primary Insurance

Insurance name _____ Subscriber's name _____

Insurance ID#:_____

DOB _____ Relationship to insured_____

Secondary Insurance

Insurance name _____ Subscriber's name _____

Insurance ID#: _____

DOB _____ Relationship to insured _____

Please sign up for the patient portal to receive Lab Results

It is our policy to notify you of **test results** ordered by this office. Usually lab results **will be** posted on the patient portal within 2 weeks of being done.