WEISER
MEMORIAL HOSPITAL
SURGICAL & SPECIALTY CLINIC

PATIENT REGISTRATION

Today's Date: _____

Patient Legal Last Name	First Name Middle Initial	Preferred Name
Address	Gender ☐ Male ☐ Female ☐ Other	Date of Birth / /

City	State	Zip	Primary Care Provider

Email Address	Previous X-rays of affected area? ☐ Yes ☐ No Date X-Rays Taken: / /

Primary Phone: ☐ Home ☐ Cell ☐ Work	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Partnered	Would you like your records transfered? ☐ Yes ☐ No What facility were the X-rays taken?

Guarantor Name (if other than patient)	Patient Relationship to Guarantor ☐ Spouse/Partner ☐ Child ☐ Other	Guarantor Date of Birth / /

Address (if different than patient)	Phone Number: ☐ Home ☐ Cell ☐ Work

Insurance Information

Primary Insurance Company		Secondary Insurance Company	
Address		Address	
ID Number	Group Number	ID Number	Group Number
Group Name or Employer		Group Name or Employer	
Subscriber Name (If other than patient)		Subscriber Name (If other than patient)	
Subscriber Relation to Patient	Date of Birth / /	Subscriber Relation to Patient	Date of Birth / /

Emergency Contact

Name	Phone Number(s)	Relationship

How did you hear about Family Medical Center?
☐ Newspaper ☐ Social Media ☐ Community Event ☐ Hospital ☐ Referral ☐ Other

Race? *(Federal Statistics and Administration reporting for medical research purposes)*
☐ I decline to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Two or more races
☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ White

Ethnicity? *(Federal Statistics and Administration reporting for medical research purposes)*
☐ I decline to answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language _____ ☐ Interpreter Needed

Preferred Pharmacy Name & Location _____

ACCREDITED Critical Access Hospital