



# Stanly Medical Services

## Patient Registration

### Please Print Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ MI  
Last First

Mailing Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Zip  
City State

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Ok to Leave Message? Y / N

Contact Preference  Phone  Email  Letter

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Email \_\_\_\_\_ Sex  M  F Ethnicity  Hispanic  Non-Hispanic

Race  Asian  Native Hawaiian  Black or African-American  White  Hispanic  Pacific Islander  Other

Employer \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Mail Order Pharmacy \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Contact Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

### Parent/Guardian/Spouse Information (If Applicable)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (If different from above) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

### Additional Parent/Guardian Information if applicable

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (If different from above) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

**VFC Eligibility**  Unknown  Non VFC Eligible  AHCCCS (Medicaid/Medicare)  Uninsured  American Indian/Alaska Native  Underinsured

### Insurance Information

(Please give insurance cards to receptionist to copy.)

If Stanly Medical Services is contracted with your insurance carrier and your visit is for a covered service, then we will file a claim for you, and collect any co-pay, coinsurance and deductible at the time of service. If we are not contracted with your insurance carrier or your visit includes non-covered services, you are responsible for payment at the time of services.

Prime Insurance: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders' D.O.B.: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders' D.O.B.: \_\_\_\_\_

Tertiary Insurance: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders' D.O.B.: \_\_\_\_\_