PRIMARY CARE | INTERNAL MEDICINE | URGENT CARE

2044 BRIDGEPORT AVE. MILFORD, CT
P: 203.878.1006
F: 203.878.7043

3017 MAIN ST. STRATFORD, CT
P: 203.683.0625
F: 203.683.0273

Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name: M.I.:	Previous Name (if applicable)

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number:
☐ Home ☐ Cell ☐ Work

Family Physician or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender

Marital Status:
☐ Divorced ☐ Married ☐ Single ☐ Other______________________

Social Security #:

Employer Name:	Emergency Contact Name:
Emergency Contact Phone #:	Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:	Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select):
☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil)
☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have reviewed a copy of MD CARE NOW's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X______________________________ **Date:**

Printed Name of Responsible Party: X______________________________ **Date:**