ME Cares

Patient #: _____ **Registration** Date: _____

Name: _____
Last First Middle Maiden

Address: _____
Street or P.O. Box City State Zip

Name of Guardian (if applicable): _____

Telephone		OK to call you there?		OK to leave message?		Preference?
Home	_____	Yes ___	No ___	Yes ___	No ___	_____
Work	_____	Yes ___	No ___	Yes ___	No ___	_____
Cell	_____	Yes ___	No ___	Yes ___	No ___	_____

Email Address: _____ OK to email you? Yes____ No_____

Place of Employment: _____

SS #: _____ Date of Birth: _____ Age: _____ Gender: M F

Ethnicity (please circle): Asian African American Native American Caucasian Hispanic Other

Marital Status (please circle): Single Married Separated Divorced Widowed

Name of Spouse: _____

Children: (please include ages and indicate if relationship is step or adopted)

_____ _____

_____ _____

Emergency Contact Information

_____
Name Address Phone Relationship

Family Physician: _____
Name Address Phone

Insurance Information

Insurance Company: _____

Insured's Name: _____
Last First Middle

Address: _____
Street or P.O. Box City State Zip

Patient's Relationship to Insured: Self Child Spouse Other

Group #: _____ Policy #: _____ Effective Date: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Date of Birth: _____ Social Security #: _____ Gender: M F

Employer: _____

Signature: _____ Date: _____