

# Drum Hill Primary Care

## PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female Marital Status: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Email: \_\_\_\_\_ Race: \_\_\_\_\_ Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Contact Preference: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How did you hear about us? (check all that apply) \_\_\_ Facebook/Instagram \_\_\_ Online search (Google, Bing, etc.) \_\_\_  
Yelp \_\_\_ Friends/Family \_\_\_ Healthgrades/Vitals \_\_\_ Practice/Hospital website \_\_\_ Other:  
\_\_\_\_\_

## PHARMACY:

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Is this a Mail Order Pharmacy? \_\_\_ YES \_\_\_ NO

## INSURANCE INFORMATION:

Insurance Co. Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F  
Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_  
 Check here if address is same as patients or add current Address: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION: (Fill this Section only if this registration is for a child under 18)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Check here if address is same as patients or add current Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Contact Preference: \_\_\_\_\_

***Please hand receptionist all current insurance cards and photo identification once you have completed this form. Co-Payments will be collected at time of visit.***