DIAGNOSTIC CLINIC

Your One-Stop Medical Home!

Thank you for choosing Diagnostic Clinic for your healthcare needs. We want to become your One-Stop Medical Home! We have scheduled time prior to your first appointment to complete a brief, new patient registration. Please have your Driver's License or State ID card available. We will also need to make a copy of your insurance card (or cards) to ensure accurate billing. Completing the questions below will speed the registration process.

Patient's Name: First _____ M.I. _____ Last _____

Patient's Date of Birth: (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Is the address on your Driver's License accurate as of today? YES _____ NO _____
If no, please use the spaces below to tell us your current address.

PRIMARY ADDRESS

_____
STREET

_____
CITY STATE ZIP CODE

ALTERNATE ADDRESS

_____
STREET

_____
CITY STATE ZIP CODE

What is your Social Security Number? ___ ___ ___ - ___ ___ - ___ ___ ___ ___
(We use your SSN to prevent fraud and account duplication)

What is the best phone number to reach you? HOME CELL (_____) _____ - _____

What is an alternate phone number? WORK HOME CELL (_____) _____ - _____

What is your marital status? SINGLE MARRIED DIVORCED WIDOWED OTHER

Who is your current employer? _____ **Phone**: (_____) _____ - _____

UNEMPLOYED CHILD STUDENT RETIRED DISABLED OTHER? _____

E-Mail Address? _____

What is your race? AFRICAN AMERICAN ASIAN CAUCASIAN CHINESE FILIPINO HISPANIC JAPANESE NATIVE AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER OTHER? _____

If there were ever an <u>emergency</u>, who should we call or contact? _____

What is this person's relationship to you (the patient) ? _____

What is the best phone number to reach this person? (_____) _____ - _____ Home Work Cell

What is the second phone number to reach this person? (_____) _____ - _____ Home Work Cell

Is the Patient the primary policy holder on the insurance plan? YES _____ NO _____
If no, please provide us with the following information on the primary policy holder:

What is the patient's relationship to the primary policy holder? Spouse Child Other? _____

What is his/her name? First _____ M.I. ____ Last _____

What is his/her date of birth? (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

What is his/her Social Security Number? ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Who is his/her employer? _____

Name of Responsible Party? _____ **Phone:** (_____) _____ - _____

Name of Primary Care Physician, if not in the Diagnostic Clinic? _____

How did you hear about Diagnostic Clinic? Newspaper Yellow Pages Friend/Family/Physician Internet/Insurance

OFFICE USE ONLY – DO NOT SCAN THIS SIDE