ANCHOR
MEDICAL GROUP

Patient Registration

Name: _____Date of Birth: _____ /_____ /_____
FIRST MIDDLE LAST

Gender: ☐ Female ☐ Male ☐ Other: _____ *SSN: _____

Race: _____ Ethnicity: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work: (_____) _____ Cell: (_____) _____

May we leave messages from this office on your voicemail? ☐ Yes ☐ No

Email Address: _____

Emergency Phone: (_____) _____ Name: _____ Relationship: _____

If patient is a child:
Who may authorize treatment for this child? _____
Relationship to Patient: _____ Phone: (_____) _____
School Name: _____

How did you hear about us? ☐ Website ☐ Insurance Plan ☐ Phone Book ☐ Dr. _____
☐ Family/Friend (Name) _____ ☐ Other_____

Preferred Pharmacy and Location (e.g. Costco on Dimond): _____

_____ _____
Patient or Guardian Signature Date

PRIMARY INSURANCE *(Please provide card)*
Insurance Name: _____ Relationship to Subscriber: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____ /_____ /_____
ID #: _____ Group #: _____ Subscriber's SSN: _____

SECONDARY INSURANCE *(If applicable)*
Insurance Name: _____ Relationship to Subscriber: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____ /_____ /_____
ID #:_____ Group #:_____ Subscriber's SSN: _____