Stanly Medical Services

Patient Registration

Please Print Information

Date ______________________

Patient Name ______________________ , ______________________ , ________
Last First MI

Address ______________________ , ______________ , ____________ , ________
City State Zip

Home Phone # ____________ Work Phone # ____________ Cell Phone # ____________ Ok to Leave Message? Y / N

Social Security # ______________ Date of Birth ______________ Marital Status ______________

Email ______________________ Sex ☐ M ☐ F Ethnicity ☐ Hispanic ☐ Non-Hispanic

Race ☐ Asian ☐ Native Hawaiian ☐ Black or African-American ☐ White ☐ Hispanic ☐ Pacific Islander ☐ Other

Employer ____

Preferred Pharmacy ______________________ Mail Order Pharmacy ______________________

Emergency Contact ______________________ Relationship to patient ______________________

Contact Phone # ______________ Work Phone # ______________ Cell Phone # ______________

Parent/Guardian/Spouse Information (If Applicable)

Name ______________________ Relationship to patient ______________________

Address (If different from above) ____

Home Phone # ______________ Work Phone # ______________ Date of Birth ______________

Social Security # ______________ Employer ______________________

Additional Parent/Guardian Information if applicable

Name ______________________ Relationship to patient ______________________

Address (If different from above) ____

Home Phone # ______________ Work Phone # ______________ Date of Birth ______________

Social Security # ______________ Employer ______________________

VFC Eligibility ☐ Unknown ☐ Non VFC Eligible ☐ AHCCCS (Medicaid/Medicare) ☐ Uninsured ☐ American Indian/Alaska Native ☐ Underinsured

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Insurance Information

(Please give insurance cards to receptionist to copy.)

If Stanly Medical Services is contracted with your insurance carrier and your visit is for a covered service, then we will file a claim for you, and collect any co-pay, coinsurance and deductible at the time of service. If we are not contracted with your insurance carrier or your visit includes non-covered services, you are responsible for payment at the time of services.

Prime Insurance: ____

Policy Holders Name: ______________________ Policy Holders' D.O.B.: ______________

Secondary Insurance: ____

Policy Holders Name: ______________________ Policy Holders' D.O.B.: ______________

Tertiary Insurance: ____

Policy Holders Name: ______________________ Policy Holders' D.O.B.: ______________

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