Boise Family Medicine Center

Patient Registration

Date: ______________________ *Payment Expected at the Time of Service*

Patient	Last Name ______ Initial ____ First Name ______ Social Security Number ______ Date of Birth ______ Sex ______ Address ______ City ______ State ______ Zip ______ Phone - Home ______ Work ______ Cell ______ Preferred Message/Contact Phone ______ Marital Status ______ Employer ______ Who was your last Medical Provider? ______
Health Insurance	**Primary Insurance** ______ Policy Holder Name ______ Relationship to Patient ______ Date of Birth ______ Employer ______ Subscriber Name ______ Group Number ______ Effective Date ______ **Secondary Insurance** ______ Policy Holder Name ______ Relationship to Patient ______ Date of Birth ______ Employer ______ Subscriber Name ______ Group Number ______ Effective Date ______
Responsible Party	Last Name ______ Initial ____ First Name ______ Social Security Number ______ Date of Birth ______ Sex ______ Address ______ City ______ State ______ Zip ______ Phone - Home ______ Work ______ Cell ______ Preferred Message/Contact Phone ______ Marital Status ______ Employer ______
In Case of Emergency	**1st Contact Info** - Last Name ______ First Name ______ Address ______ City ______ State ____ Zip ______ Phone # ______ Relationship to Patient ______ **2nd Contact Info** - Last Name ______ First Name ______ Address ______ City ______ State ____ Zip ______ Phone # ______ Relationship to Patient ______
Advance Directives	Do you have an Advance Directive? Yes ______ No ______ If yes, please provide our office with a copy for your chart

Name ______	Name ______	Name ______
Date ______	Date ______	Date ______