WELLSPRING
FAMILY PRACTICE

Patient Registration *(please print clearly)*

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Birth Sex: ☐ Male ☐ Female

SSN: _____ Driver License #: _____ Preferred Language: _____

I identify as: ☐ Female ☐ Female-to-Male Transgender ☐ Non-Conforming
☐ Male ☐ Male-to-Female Transgender
☐ Other: _____ ☐ Decline to answer

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American
☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced

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

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

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell Email: _____

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

Preferred Pharmacy: _____ Appointment Reminders OK? ☐ Yes ☐ No

Ok to leave message on: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Phone: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize WellSpring to provide my insurance companies with all information necessary to process insurance claims and assign payments to WellSpring all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: _____ Date: _____

A part of allcare Medical Group

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