Journey
Family Medicine

Patient Pre-Registration

Full Name (First, Middle, Last): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Preferred Phone: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Sex: _____ Pronouns: _____

Primary Insurance Information

Insurance Name: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____

Sex (Required by insurance for billing purposes): ☐ M ☐ F Insured Party Date of Birth: _____

Secondary Insurance Information

Insurance Name: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____

Sex (Required by insurance for billing purposes): ☐ M ☐ F Insured Party Date of Birth: _____

Current Medications (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs, etc.)

Medication	Dose	Time/Day

Signature: _____ Date: _____