Journey
Family Medicine

Pre-Registration

Full Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: _____ Pronouns: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ SSN: _____

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

Preferred Phone: ☐ Cell ☐ Home ☐ Work Initial to consent to leave a detailed message: _____

Primary Insurance Information

Insurance Name: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____

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

Current Medications (Please note, we do not routinely prescribe most long-term, controlled medications.)

Medication	Dose	Time/Day

Signature: _____ Date: _____