link COMMUNITY CLINIC

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Last Name	First name	Middle Name	
Date of Birth (DOB)	Social Security Number (SSN)	Preferred name	Gender
Street Address	City	State	Zip
Email Address	Primary Language	Interpreter requested?	☐ Yes ☐ No

Home phone	Can we leave a detailed voicemail?	☐ Yes ☐ No	Cell Phone	Can we leave a detailed voicemail?	☐ Yes ☐ No	Work Phone

EMERGENCY CONTACT INFORMATION

Emergency contact Name	Relationship to Patient	
Cell Phone	Home Phone	Work Phone

PRIMARY CARE PROVIDER INFORMATION

Primary Care Provider Name	Facility Name and Address

☐ *Check here if you'd like to establish primary care at Link Community Clinic*

PHARMACY INFORMATION

Name of Pharmacy	Phone number		
Street Address	City	State	Zip

RESPONSIBLE PARTY INFORMATION ☐ Check here if same as patient

Last Name	First Name	MI	Preferred Name
DOB	SSN	Relationship to Patient	Phone
Street Address	City	State	Zip

PRIMARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number	
Subscriber Name	SSN	Date of Birth	Relationship to Patient

SECONDARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number	
Subscriber's Name	SSN	Date of Birth	Relationship to Patient

CLINIC QUESTION

How did you hear about us? (Check all that apply)

☐ Friend/Family ☐ Social Media ☐ Physician

☐ Walk/Drive By ☐ Internet Search ☐ Other (Please specify) _____