

AR # \_\_\_\_\_



# EAGLE PHYSICANS PATIENT REGISTRATION SHEET

Patient Name: \_\_\_\_\_  
Last First Middle

Birth Date: \_\_\_\_\_ Sex Assigned at Birth: Male Female Uncertain/Intersex  
Month Day Year

Sexual Orientation (optional): \_\_\_\_\_ Gender Identity (optional): \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
(Single/Married/Divorced/Widow/Other)

Home Address: \_\_\_\_\_  
Street Apt#/Lot#

\_\_\_\_\_ City State Zip

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_

### Race and Ethnicity

Please Check **Race/s**:

- American Indian or Alaska Native
- Asian
- Native Hawaiian
- Black or African American
- White
- Hispanic
- Other Race
- Other Pacific Islander
- Decline to Report

Please Check **Ethnicity**:

- Hispanic
- Non-Hispanic
- Decline to Report

Please Check **Language/s**:

- Arabic
- Chinese
- English
- French
- German
- Greek
- Hindi
- Indian (incl Hindi and Tamil)
- Italian
- Japanese
- Other \_\_\_\_\_
- Decline to Report

AR # \_\_\_\_\_

**If Patient is a Minor:**

Parent/Guardian Name: \_\_\_\_\_  
Last First Middle

Parent/Guardian Address: \_\_\_\_\_  
Street Apt#/Lot#

\_\_\_\_\_  
City State Zip

Home/Cell # \_\_\_\_\_ Work Phone # \_\_\_\_\_

**Insurance Information**

Primary Insurance Company Name: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Policyholder Date of Birth: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Policyholder Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Payer ID: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Policyholder Date of Birth: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Policyholder Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Payer ID: \_\_\_\_\_

**I hereby confirm that the information provided on this form is accurate and correct to the best of my knowledge.**

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_