Oakland Family Practice
*A Division of Michigan Healthcare Professionals, P.C.*
1385 E. 12 Mile Road
Madison Heights, Michigan 48071

# PATIENT REGISTRATION

Name: _____
(Last) (First) (Middle)

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Age: _____ Date of Birth: _____ Sex:_____ Marital Status: _____

Phone: (_____) _____ Alternative Phone: (_____) _____

Social Security #: _XXX_ - _XX_ - _____ Work Phone: (_____) _____

Employer: _____ Occupation: _____

Race: (Circle One) White African American American Indian / Alaskan Asian Hawaiian / Pacific Islander Other Declined to Answer

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Language: English Other: _____

## PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Insurance Card Holder Name: _____ Card Holders Date of Birth: _____

Card Holder Social Security #: _____ - _____ - _____ Relationship to Card Holder: ☐ Self ☐ Spouse ☐ Dependent

Spouse's / Parent's Name: _____

Spouse / Parent's Employer: _____ Employer Phone #: (_____) _____

## SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

Insurance Card Holder Name: _____ Card Holders Date of Birth: _____

Card Holder Social Security #: _____ - _____ - _____ Relationship to Card Holder: ☐ Self ☐ Spouse ☐ Dependent

## IN CASE OF AN EMERGENCY

Contact: _____ Relationship: _____

Phone: (_____) _____ Alternative Phone: (_____) _____

Medication Allergies: _____

Pharmacy Name: _____Pharmacy Location / Phone #: _____

How or who referred you to our office? (Circle One)

Internet Sign (Drive By) Family or Friend Insurance Company