IRMC
PHYSICIAN GROUP
THE COMMUNITY'S CHOICE

Patient Registration Form

* All fields marked with an asterisk must be filled out

*** Patient Name:** _____ Last _____ First _____ M.I. _____ * Date of Birth

***Address:** _____ Street / P.O. Box _____ City _____ State _____ Zip Code

Country: _____ **County:** _____

*** Email:** _____

**You will receive IRMC Physician Group monthly eNewsletter and gain access to IRMC.me patient portal. Staff will ask you to answer a security question for portal access.*

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Preferred Communication: ☐ Home ☐ Work ☐ Cell

SS #: _____/_____/_____ **Preferred Name:**_____

Maiden Name (if applicable): _____

Marital Status: ☐Single ☐Married ☐Widowed ***Gender:** ☐Male ☐Female ☐Other: _____

Race: _____ **Religion:** _____

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Unknown ☐Decline

***PCP Name:** _____

*** Preferred Pharmacy:** _____ **Phone #:** (_____)_____-_____

Referred by: ☐Physician ☐Friend ☐Newspaper ☐Radio ☐Insurance ☐Internet ☐Referred by Patient ☐Established Patient

Referring Physician's Name: _____ Other: _____ ☐IPG Physician ☐Direct to Consumer

Insurance Information

***Subscriber Name:** _____ ***Subscriber's D.O.B:** ____/_____/_____

Emergency Contact Information

***Name:** _____ **Relationship:** _____ **Phone #:** _____ **D/O/B:** _____

***Name:** _____ **Relationship:** _____ **Phone #:** _____ **D/O/B:** _____

Work Status (if retired)

Date of Retirement (if applicable): _____

Date of Spouse's Retirement (if applicable): _____

This information is required for Medicare.

I hereby authorize consent for treatment and release of any necessary information acquired in the course of examination and treatment by my physician for processing of my medical exam.

_____ Signature of patient/insured/legal guardian

_____ Date