FRONTIER MEDICAL & BEHAVIORAL CENTER

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Patient Registration Form

[ ] New Patient [ ] Annual Information Update

Patient Demographics

Patient Name: ______________________________ DOB: __________ Age: ______

Preferred to be addressed as: ____________________________ Gender: [ ] Male [ ] Female

Street Address: ______________________ City:__________ State:______ Zip:_____

Home Phone: ____________ Cell Phone: ____________ Patient Portal Sign up? [ ] Y [ ] N

Email: ___________________________________

Race: [ ] Asian [ ] Black/African American [ ] White/Caucasian [ ] Hispanic

[ ] Native Hawaiian / Other Pacific [ ] Other: ______________

Ethnicity: [ ] Hispanic [ ] Non – Hispanic [ ] Prefer not to disclose

Primary Language: [ ] English [ ] Spanish [ ] Other: ______________

Insurance

Primary Insurance: ___________________ Subscriber ID#: _____________________

Subscriber name: ____________________Relationship to patient: _________________

Secondary Insurance: _________________ Subscriber ID#: _____________________

Subscriber name: ____________________ Relationship to patient: _________________

Occupation: _______________________ Employer: _________________________

Employer Address:____

Emergency Contact

Name of local relative (not living in the same household):___________________________

Relationship to patient: ________________ Phone: ______________ Work:________

PHARMACY: ____

____ (initial) It is my responsibility to update all above information in case of changes

________________________ ____________________ _____________

Printed Patient / Guardian Name Signature Date

5105 Camino Al Norte Suite 100 N Las Vegas, Nevada 89031

P: 702.750.2438 | F: 702.750.2173 | E: info@frontiermbc.com