Health First Medical Group | PRIVIA PROVIDER NETWORK

Patient Registration

Patient Name

Last Name _____
First Name _____
Middle Name _____
Former Last Name _____
Sex _____
Date of Birth _____
SSN _____
Address _____
Address 2 _____
City _____
State _____
ZIP _____
Home phone _____
Mobile phone _____
Work phone _____
Email (required) _____
Preferred Pharmacy _____
Contact preference ☐ Home ☐ Mobile ☐ Work
Language _____
Race _____
Ethnicity _____
Marital Status _____
Homebound? ☐ Yes ☐ No

How did you hear about us?

☐ Advertising ☐ Primary Care Physician
☐ Specialist Physician ☐ Word of Mouth ☐ Insurance
☐ Patient in Practice ☐ Hospital ☐ Other

Specify (if other, above) _____

Today's Date _____

Guardian

Last Name _____
First Name _____
Middle Name _____

Emergency Contact

Name _____
Relationship _____
Home phone _____
Mobile phone _____

Next of Kin

Name _____
Relationship _____
Phone _____

Employment

Employer name _____
Employer phone _____

Guarantor Information

Last Name _____
First Name _____
Middle Name _____
Date of Birth _____
Address _____
Address 2 _____
City _____
State _____
ZIP _____

Optional information

SSN _____
Phone _____

Primary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address 2 _____

City _____

State _____

ZIP _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address 2 _____

City _____

State _____

ZIP _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____