
# Welcome to our Family Practice
# Patient Registration

*We look forward to caring for you*

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*Office use*
Ins: ☐
Dem: ☐
Scan: ☐

***-- PLEASE PRINT CLEARLY --***

## Patient Information

**Name:** Last_____First_____Middle Initial_____

**Date of birth**_____/_____/_____ **Sex:** ☐Male ☐Female **Social Security No.** _____-_____-_____

**Marital Status**_____

**1st Language**_____

2nd Language_____

**Ever used tobacco?** ☐Yes ☐No

How much? _____

Currently?____Since when? _____

**Ethnicity**
- ☐ Hispanic / Latino
- ☐ Non-Hispanic / Non-Latino
- ☐ Unknown
- ☐ Decline to state

**Race**
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic
- ☐ Native Hawaiian / Pacific Islander
- ☐ White
- ☐ Unknown
- ☐ Decline to state

## Patient Contact

**Address:**_____City_____State_____Zip_____

**Preferred Phone:** (  )_____-_____ ☐Cell ☐Home **Other:** (  )_____-_____ ☐Home ☐Work

**Email** (used for portal invite)**:**_____ **Preferred Contact:** ☐Portal ☐Phone

Employer:_____ Occupation:_____

Address_____City_____State_____Zip_____

## Emergency Contact

**Primary Contact:** Last_____First_____ Relation_____

**Address**_____City_____State_____Zip_____

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

**Secondary Contact:** Last_____First_____ Relation_____

**Address**_____City_____State_____Zip_____

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

## Insurance Information

**Primary Insurance:**_____ **Plan#** _____

**Subscriber Name:** Last_____First_____ **Relation**_____ **Sex:** ☐Male ☐Female

**DOB:** _____/_____/_____ **Group#**_____ **Effective Date**_____/_____/_____

**Secondary Insurance:**_____ **Plan#** _____

**Subscriber Name:** Last_____First_____ **Relation**_____ **Sex:** ☐Male ☐Female

**DOB:** _____/_____/_____ **Group#**_____ **Effective Date**_____/_____/_____

## Patient Preferences & Questions

Preferred Pharmacy_____ Street, City_____

What does Excellent healthcare look like to you? _____

_____

Do you have any special needs?_____

***Please fill out backside***

**Patient Name** Last_____ First_____ **DOB**_____/_____/_____

## Recommendations For All Patients

You are encouraged to complete an Advance Directive, designating your wishes should you become incapacitated. This is especially important as you get older or have health problems. We can keep this information on file to help treat you and guide your family should the need arise. Go to http://oag.ca.gov/ and search Advance Directive for more information.

## ***FollowMyHealth – Patient Portal***

**We provide an excellent service to our patients with the help of our patient portal called "FollowMyHealth." Just by being our patient you have an account. This free service allows you to update personal health information, access to lab results and view medical history. You will be able to ask questions, request/cancel appointments, get lab results and request medication refills.**

**Please provide us with your Gmail or Yahoo email and we will send you an invite. Once you receive this invite you can register and access your FollowMyHealth account.**

## Authorization, Assignment & Privacy Practices Acknowledgment

I authorize John W. Wilson, MD, Inc. to provide medical care and treatment, and to release information that may be requested by insurance companies to whom claims have been submitted. I hereby request my current insurance company or companies to pay John W. Wilson, MD, Inc., PO Box 2248, Daly City, CA 94017-2248, all benefits accruing to me under my surgical, hospitalization and medical plan(s). I hereby certify that I am eligible with the insurance plan(s) referenced above and that I have chosen John W. Wilson, MD as my medical provider, regardless of whether or not he is a participating provider with my plan. I consent to be contacted at any of the phone numbers, fax or email listed above and to notify this office of any changes in the above information.

***Initial*_____** I understand I am financially responsible to the physician for all charges not covered by this assignment.

***Initial*_____** I understand that if am not eligible, or do not have insurance, I am responsible for all charges for service rendered

***Initial*_____** I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**Name (Print) _____Date of birth** _____/_____/_____

**Signature_____ Date**_____/_____/_____