Patient Registration

The Kimberton Clinic
Richard G. Fried, M.D.

****Please print and fill in ALL fields**

Date:_____

Patient Name: _____
First **MI** **Last**

Sex: M or F **Birthdate:** _____ **SS#:** _____

Email: _____ **Cell Phone:** _____

Home Phone #: _____ **Work Phone:** _____

Preferred Method of Communication? _____ **Email or text notifications? Yes or No**

Address: _____ **County:** _____

City: _____ **State:** _____ **Zip:** _____

Single Married Widowed Divorced

Ethnicity: _____ **Preferred Language:** _____ **Race:** _____

Insurance Company: _____

ID#: _____ **Group #:** _____

Copay: _____ **Subscriber Name:** _____

Address if different than patient: _____

Subscriber Birthdate: _____ **Subscriber SS#:** _____

Relationship to patient: _____

Secondary Insurance: _____

ID#: _____ **Group#:** _____

Copay: _____ **Subscriber Name:** _____

Address if different than patient:_____

Subscriber Birthdate: _____ **Subscriber SS#:** _____

Relation to Patient: _____

List Current Medications (use back of paper if necessary)

_____

_____

_____

_____