Rebecca Gladding, MD
Medical Director

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REGISTRATION INFORMATION

(Please only fill out information that you have not filled out online)

Today's Date: ____________________________ Date of Birth: _____________ Last 4 of SSN: _________________

Full name: ____ Preferred Name: ______________________

Home address: ____

City/State/Zip code: ____

Employer: _______________________________ Primary Care Provider: ________________________________

Did your PCP refer you to us? Yes No

Contact information: (please include area code)

Home: ________________________________ Cell: ____

Work: ________________________________ Email: ____

Preferred Contact Method: Home Phone Cell Phone Work Phone Patient Portal Mail

Appointment Reminders: ***Consent to Call*** Yes No ***Consent to Text*** Yes No

Next of Kin or Emergency contact:

Name: ____

Phone number: ____

Insurance information: (please present cards and ID)

Primary Insurance Provider: HMSA HMAA UHA BCBS Other: ____________________

HMO PPO

Subscriber name: _______________________________ ID/Membership #: ___________________________

Coverage code: _________________________________ Group #: ___________________________________

Subscriber Address if Different from Above: ____

Secondary Insurance Provider: HMSA HMAA UHA BCBS Other: ________________

HMO PPO

Subscriber name: _______________________________ ID/Membership #: ___________________________

Coverage code: _________________________________ Group #: ___________________________________

Subscriber Address if Different from Above: ____