UT★Physicians

NEW PATIENT REGISTRATION FORM

Last Name:_____ First Name:_____ M.I.:_____
Date of Birth: _____ Race:_____ ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address:_____ Apt #: _____
City: _____ State: _____ Zip Code:_____ County:_____
Home Phone #:_____ Cell Phone #:_____
Employed: ☐ Yes ☐ No ☐ Retired ☐ Disabled (If employed, fill out employer information below)
Employer: _____ Occupation: _____
Address:_____
City: _____ State: _____ Zip Code:_____
Phone #:_____ Length of Employment: _____ ☐ Years ☐ Months
E-mail Address: _____ ☐ Enroll in My UTP Patient Portal

SPOUSE INFORMATION

Last Name:_____ First Name:_____ M.I.:_____
Date of Birth: _____
Is spouse employed? ☐ Yes ☐ No ☐ Retired Is patient covered by spouse's insurance? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Relationship to patient: ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Other
Last Name:_____ First Name:_____ M.I.:_____
1 Phone #:_____ 2 Phone #: _____
Relationship to patient: ☐ Spouse ☐ Child ☐ Mother ☐ Father ☐ Other
Last Name:_____ First Name:_____ M.I.:_____
1 Phone #:_____ 2 Phone #: _____

CLINIC INFORMATION

Family M.D.: _____ Reason for visit: _____
Referring M.D.: _____ Phone#: _____
Pharmacy name: _____ Phone #: _____
Pharmacy Address: _____ Phone #: _____
Mail Order Pharmacy Name: _____ Fax #: _____
Mail Order Pharmacy Address: _____ Phone #: _____
Fax #: _____

PAYMENT PLAN

☐ Medicaid ☐ Medicare ☐ Commercial ☐ Self-Pay ☐ Workmen's Comp ☐ PPO ☐ Market Place Insurance
Plan Name:_____ Insured Relationship to Patient:_____
Insured: _____ Is this PPO? ☐ Yes ☐ No
Insured Date of Birth:_____ Policy #:_____ Group #:_____
Group Name:_____ Benefits Phone #:_____
Claims Address:_____
City: _____ State: _____ Zip Code:_____ County:_____
Secondary Insurance: ☐ Medicaid ☐ Medicare ☐ Commercial ☐ Market Place Insurance
Plan Name: _____ Insured Relationship to Patient: _____
Insured: _____ Is this PPO? ☐ Yes ☐ No
Insured Date of Birth:_____ Policy #:_____ Group #:_____
Group Name:_____ Benefits Phone #:_____
Claims Address:_____
City: _____ State: _____ Zip Code:_____ County:_____