memorial regional health

Date: Please fill out form completely **Adult Intake**

Legal Name: _____ Birth Date: _____ Birth Sex: M or F

Preferred Name: _____ Gender Identity: M ☐ F ☐ Trans M ☐ Trans F ☐ Non-Binary/Other ☐

Mailing Address: _____

Primary Phone #:_____ Secondary Phone #:_____

Email Address: _____ SSN: _____

Employment Status: Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Unemployed ☐ Retired ☐ Student ☐

Primary Care Physician: _____ Religious Preference: _____

Marital Status: _____ Race: _____ Ethnicity: Hispanic ☐ Non-Hispanic ☐ Language: _____

Preferred Pharmacy: MRH Community Pharmacy ☐ City Market ☐ Walmart ☐ Walgreens ☐ Other: _____

Primary Insurance: _____ Member ID: _____

Subscriber Name: _____ Subscriber ID: _____

Group #: _____ Effective Date: _____ Provider Phone #: _____

Claims Address: _____

Secondary Insurance: _____ Member ID: _____

Subscriber Name: _____ Subscriber ID: _____

Group #: _____ Effective Date: _____ Provider Phone #: _____

Claims Address: _____

*****Please provide the registration team with your Insurance ID Card(s) to ensure accurate billing for your visit*****

Emergency Contact Name: _____ Relationship: _____

Primary Phone #:_____ Secondary Phone #:_____