New Patient Registration Chart #_____

Name (First / Middle / Last)_____

DOB (mm / dd / yyyy)_____ **Social Security** _____

Address_____ **City**_____ **State**____ **Zip Code**_____

Home Phone_____ **Cell Phone** _____
Would you like to receive text messages? ()Yes ()No

Email Address _____

Portal Access: Skypoint Medical Center is pleased to provide you with online access to your health information through our Patient Portal. Here you can view and create new appointments with our practice, exchange secure messages with our staff, update your contact information and insurance, read and print important forms, and access lab results and the latest data on Health . If you want to access an email will be sent to you. Would you like access ?Yes () No ()

Ethnicity: (CIRCLE)
1. American Indian or Alaskan Native
2. Asian
3. Black or African American
4. Native Hawaiian or Pacific Islander
5. White
6. Latino / Hispano

Other_____

Martial Status: M / D / S / W

Languages(1st)_____(Other)_____

Emergency Contact

Name_____

Relationship_____

Phone Number _____

How did you hear about the Office? _____

Insurance Information

Name Of Primary _____ Relationship:_____ ____

DOB: _____ ___

Type Of Insurance (Please Circle) : PPO / HMO BCBS / Cigna / Humana / UHC / Medicare / Medicaid

Workers Comp / Motor Vehicle Cases

Date of Injury :_____ Claim Number:_____

Adjuster Name : _____ Adjuster Phone Number:_____

Insurance Name:_____ Insurance Phone Number : _____

Attorney Name: _____ Attorney Phone Number: _____