Brent K. Evetts, M.D.

Patient Registration **Date:__________________**

Patient Information (please print)

Legal Name: ____

Address:____

City: ____________________ State: ____________ Zip Code: ___________________

Telephone (Home): ____________________ Cellular: ________________________

Email: ___________________________ Date of Birth: ____________ Sex: M F

Employer: __________________________ Work: ____________________

Which number may we use to leave detailed messages? HOME WORK CELL

Social Security Number: _______________ Language Spoken: __________________

Race: ____________________ Ethnicity: ________________

Primary Physician (PCP): ______________________ Office Phone: _________________

Who referred you? ____________________________ Telephone: __________________

Emergency Contact:

Name:_________________________ Relation:_________ Telephone: ______________

Preferred Pharmacy & Location: ___________________________ Telephone: __________

PRIMARY INSURANCE

Insurance Name: _________________________________ Co-pmt $: _______________

Subscriber Name: _____________________ DOB: _________ Relationship: __________

ID No. or Social Security No.: __________________ Group or Plan No.: ________________

SECONDARY INSURANCE

Insurance Name: ___________________________________ Co-pmt $: ____________

Subscriber Name: __________________ DOB: __________ Relationship: ____________

ID No. or Social Security No.: __________________ Group or Plan No.: _______________

Responsible Party (if under 18 years)

Person responsible for payment: (please circle) Self Spouse Father Mother Other

Name: _________________________ Relationship: ___________________________

Address: ____

City: _________________________ State: ______________ Zip Code: __________