# Piper Family Medicine, PC

4000 River Ridge Dr NE, Suite 2
Cedar Rapids, IA 52402
p: (319) 261-1379
f: (319) 261-1382

## PATIENT REGISTRATION FORM

First Name | Middle Name | Last Name | Preferred Name

Gender | Date of Birth | Social Security Number | Marital Status

Mobile Phone | Home Phone | Work Phone

Email address (This is used for appointment reminders as well as access to your online health records.)

Street Address | City, State, Zip

Emergency Contact | Relationship | Phone Number

## INSURANCE INFORMATION:

Primary Insurance | Policy Number

Secondary Insurance | Policy Number

Guarantor Name (if patient is minor or mentally disabled) | Relationship | Phone Number

Subscriber Name | Date Of Birth | Address, City, State, Zip

Employer | Job Title

**PREFERRED PHARMACY:** _____

Preferred Language: _____

Ethnicity: (may choose more than one)

◯ American Indian/Alaska Native ◯ Hispanic/Latino ◯ Asian ◯ Black/African American

◯ Native Hawaiian/Pacific Islander ◯ White ◯ Other:_____

How did you hear about us? _____

I have been informed that Piper Family Medicine, PC has a Privacy Practice in place as required by law. I acknowledge that I can access it at: **www.piperfamilymedicine.com** and that Piper Family Medicine, PC will provide me with a copy of the Privacy Practice rule at my request.

I acknowledge that the information provided on this form is current and valid. I am responsible for payment in accordance with my insurance policy and the policy as stated at: www.piperfamilymedicine.com or will be provided with a copy by request.

Patient/Legal Guardian Signature | Date