Patient's Birthdate: _____/_____/_____

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Address: _____
(Street or PO Box) (City) (State) (ZIP)

Patient's Home Phone: (_____)_____ **Patient's SSN: _____**

Patient's Cell Phone: (_____)_____ **Patient's Employer: _____**

Patient's Occupation: _____ **Patient's E-Mail: _____**

Would you like to enroll in the Avera Chart Patient Portal? Yes_____ No_____

Please Circle: Male Female

Please Circle: Married Widowed Divorced
Separated Single

Please Circle: White African/Black American Indian/Alaskan
Hawaiian/Island Pacific Other

Please Circle: Hispanic/Latino Not Hispanic/Latino

If the patient is married, please complete the following:

Spouse's Name: _____ Spouse's SSN: _____

Spouse's Date of Birth: _____/_____/_____ Spouse's Employer: _____

Spouse's Primary Phone: (_____)_____ Spouse's Work Phone: (_____)_____

If the patient is a minor, or a student and covered under parent's insurance, please complete the following:

Father's Name: _____ Mother's Name: _____

Father's Date of Birth: _____/_____/_____ Mother's Date of Birth: _____/_____/_____

Address: _____ Address: _____

Primary Phone: (_____)_____ Primary Phone: (_____)_____

Father's Employer: _____ Mother's Employer: _____

Father's Work Number: (_____)_____ Mother's Work Number: (_____)_____

Father's SSN: _____ Mother's SSN: _____

Primary Medical Insurance:

Insurance Company Name: _____

Primary Insured's Name: _____

Employer's Name: _____

Policy/I.D. Number: _____

Group Number: _____

Patient's Relationship to Subscriber: _____

Secondary Medical Insurance: (If applicable)

Insurance Company Name: _____

Primary Insured's Name: _____

Employer's Name: _____

Policy/I.D. Number: _____

Group Number: _____

Patient's Relationship to Subscriber: _____

Patient Contacts:

Person to Notify:

Relationship to Patient: _____

Last Name: _____

First Name: _____

Phone Number: (_____)_____

Discuss Patient's Healthcare:

Appointments (e.g. dates)	Yes	No
Clinical (e.g. test results)	Yes	No
Financial (e.g. balance due)	Yes	No

Person to Notify 2:

Relationship to Patient: _____

Last Name: _____

First Name: _____

Phone Number: (_____)_____

Discuss Patient's Healthcare:

Appointments (e.g. dates)	Yes	No
Clinical (e.g. test results)	Yes	No
Financial (e.g. balance due)	Yes	No

Patient Signature: _____

Parent/Guardian (If a minor): _____

Date: _____