## *Patient Registration Information*

Dry Ridge Nicole Ogg, MD FAMILY MEDICINE PLLC

Date _____

**Last** Name _____ First Name _____ MI ___

Date of Birth _____ Gender _____ Nickname _____

**Mailing** Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Email _____

Phone (Cell) _____ Phone (Work) _____

Preferred # for us to contact you: ☐Home ☐Work ☐Cell

Employer/School Name_____

**Census Data**

Race: ☐American Indian & Alaskan Native ☐Asian ☐Black or African American ☐Black Hispanic or Latino ☐Native Hawaiian & Other Pacific ☐White ☐White Hispanic or Latino ☐Refuse to Answer

Language: ☐English ☐Spanish Other_____

Marital Status: ☐Single ☐Married ☐Other Partner Name _____

Emergency Contact Name _____ Phone _____

Preferred Pharmacy for Prescriptions: _____

How did you hear about us? _____

**Person Responsible for the Bill:** ☐Self* ☐Spouse ☐Parent ☐Other _____

*If self, you do not need to complete this section

Last Name _____ First Name _____ MI ___

Mailing Address _____

City _____ State _____ Zip _____

Phone: _____ Gender: ☐M ☐F

Social Security #: _____ Date of Birth _____

**Insurance** ***Please bring your insurance card(s) to your appointment. If you fail to do so you will be responsible for full payment.***

Primary: ☐Medicare ☐Aetna ☐BC/BS ☐Cigna ☐Humana ☐United Healthcare ☐Self Pay ☐Other_____

Secondary: ☐Medicare ☐Medicaid ☐Aetna ☐BC/BS ☐Cigna ☐Humana ☐United Healthcare ☐Self Pay ☐Other_____