Patient Registration Information

Dry Ridge Family Medicine PLLC — Nicole Ogg, MD

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

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 _____

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, or you will be responsible for full payment.***

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

ID #: _____ Group # (if applicable) _____

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

ID #: _____ Group # (if applicable) _____