Family Medical Associates of Raleigh
Your Family Comes First

3500 Bush Street
Raleigh, NC 27609
F: 919.875.9577
P: 919.875.8150
www.fmaraleigh.com

PATIENT REGISTRATION FORM

Welcome to Family Medical Associates of Raleigh! MRN: _____

PATIENT INFORMATION *Please complete this entire form, or notify our staff if you are unable to.*

Last Name: _____ First: _____ M.I. _____

D.O.B.____/____/_____SS#_____Gender:_____Race:_____

Primary Language: _____ Ethnicity: _____ Marital Status: _____

Mailing Address:_____Apt.#_____City: _____

State: _____ Zip: _____ DL State/#: _____ Home Phone _____

Work Phone_____ Cell Phone_____ Email _____

Preferred Method of Communication: ☐ Email ☐ Text ☐ Phone Call ☐ Mail

Physical Address, if different than your mailing address: _____ Apt. #_____

City: _____State: _____ Zip: _____

Pharmacy Name and Location: _____Pharmacy Phone #: _____

Spouse's Name and phone: _____ / _____

Emergency Contact and phone: _____ / _____

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

RESPONSIBLE PARTY, IF NOT SELF (PARENT OR GUARDIAN)

Last Name: _____ First: _____ M.I. _____

D.O.B.____/____/_____SS#_____Gender:_____Race:_____

Mailing Address:_____Apt.#_____

City: _____ State: _____ Zip: _____ DL State/#: _____

INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD WITH THIS FORM)

Primary Ins. _____ Policy Holder _____ D.O.B.____/____/____

Relationship: _____ Policy # _____ Group# _____

SS# _____Employer:_____

Secondary Ins. _____ Policy Holder_____ D.O.B. ____ /____/____

Relationship: _____ Policy # _____ Group# _____

SS# _____Employer: _____