Islands Community Medical Services

ICMS

PATIENT REGISTRATION FORM

***If you do not have proof of insurance you will need to pay at the time of service.**

Patient Information

Full Name:	
Social Security #:	Date of Birth:
Email Address:	
Phone (Home):	Phone (Cell):

Primary Billing Address:

Street:	
City/State:	Zip Code:

Vinalhaven Address (If different than billing address):

Street:	
City/State:	Zip Code:

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Transgender Male/Female-to-Male
- ☐ Transgender Female/Male-to-Female
- ☐ Chose Not to Disclose

Sexual Orientation:

- ☐ Lesbian or Gay
- ☐ Straight (Not Lesbian or Gay)
- ☐ Bisexual
- ☐ Something Else
- ☐ Do Not Know
- ☐ Chose Not to Disclose

Please circle one for each of the following:

Veteran	Smoker	Hispanic	Homeless	Migrant Worker
Yes / No	Yes / No / Former	Yes / No	Yes / No	Yes / No

Preferred Language: English / Other:_____-

Race:

- ☐ White
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Decline to Specify

Family Size:_____ **Annual Income:**_____(Financial Assistance Available, Please Inquire)

Parent Information (If patient is a minor):

Mother's Name:	Father's Name:
Mother's Date of Birth:	Father's Date of Birth:
Mother's SSN:	Father's SSN:

Spouse Information (If Applicable):

Name:
Date of Birth:
Phone (Home):
Phone (Cell):

Emergency Contact Information:

Name:	
Address:	
Phone (Home):	Phone (Cell):
Relationship to Patient:	

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy #:	Policy #:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder SSN:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Prescription Coverage (If Applicable)
ID Number:
Bin Number:
PCN Number:
Group Number:
RX Group Number:

Signature:_____ **Date:**_____

(Signature of Patient, Parent or Responsible Party)