Regional Primary Care, Inc.
150 S. Mt. Auburn Rd., Ste. 418
Cape Girardeau, MO 63703
(573)332-6000

Patient Information Sheet

This document is part of your permanent record.

This section for office use.
☐ New patient ☐ Established patient Abstractor: _____ Date: _____/_____/_____

Patient Information

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Marital Status

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Language : ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ More than one race
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Unknown/Not Reported ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

Guarantor Information

(Person Responsible for Payment)

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Relationship | Marital Status

Social Security Number: _____ - _____ - _____ Date of Birth: _____/ _____/ _____ Sex: ☐ Male ☐ Female

Emergency Contact

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Relationship

Patient Name: _____ DOB: _____/ _____/ _____

Insurance

(Please Complete or attach copy of card – actual insurance card will be scanned at time of visit**)**

What is the name of your insurance provider: ❑ Medicare ❑ Medicaid ❑ BC/BS

Other (Please Specify): _____ Effective Date: _____ / _____ / _____

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_____) _____ - _____

Social Security Number of Policy Holder: _____ - _____ - _____

Insurance Identification Number: _____ Group Identification Number: _____

Employment

Status: ❑ Retired ❑ Full-Time ❑ Part-Time ❑ Unemployed Other: _____

/

Name of Employer (Company Name) Occupation

Phone Number: (_____) _____ - _____

Address

City State Zip Code

Advance Directives

Date Reviewed: _____ ❑ None ❑ DNR ❑ Living Will ❑ Durable Power of Attorney ❑ HC Proxy

Pharmacy

Preferred Retail Pharmacy

Address

City State Zip Code

Preferred Mail-in Pharmacy

Address

City State Zip Code