Office of Dr. Gennadiy Ivanov M.D.
WE CARE MEDICAL GROUP, PC
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Patient Registration Form

First Name:_____ Last Name:_____

Date of Birth: ___/___/_____ Phone #: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Primary Care Physician - Лечащий Врач

Physician Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ **Check Box if Self Paying - OR - Health Insurance/Policy Information**

Insurance Company Name: _____ Group #:_____

Member ID #: _____ *(circle)* Type: Medicaid - Employee - Private

Pharmacy Information - Аптека

Pharmacy Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Экстренный Контакт

First Name: _____ Last Name: _____

Relationship: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantor's Information Информация Поручителя

* person financially responsible for this patient's bill or dues *

* финансовую ответственность по счету или взносам этого пациента *

First Name:_____ Last Name:_____

Date of Birth: ___/___/_____ Phone #: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Relationship to Guarantor: _____

Patient's Signature: _____ Date: ____/____/_____