

# Piper Family Medicine, PC

1630 42<sup>nd</sup> St NE, Suite F  
Cedar Rapids, IA 52402  
p: (319) 261-1379  
f: (319) 261-1382

## Patient Registration Form

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First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

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Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

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Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

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Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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Email address (This is used for appointment reminders and allow you access to your online health records.) \_\_\_\_\_

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Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

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Guarantor Name (if patient is minor or mentally disabled) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

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Employer \_\_\_\_\_ Job Title \_\_\_\_\_

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Primary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

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Secondary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Ethnicity:  Non-Hispanic  Hispanic  Not Specified

Race: (may choose more than one)

White/of European descent  Black/of African descent  Asian/of Asian descent

Native American/Native Alaskan  Pacific Islander Other: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

I have been informed that Piper Family Medicine, PC has a Privacy Practice in place as required by law. I acknowledge that I can access it at: [www.piperfamilymedicine.com](http://www.piperfamilymedicine.com) and that Piper Family Medicine, PC will provide me with a copy of the Privacy Practice rule at my request.

I acknowledge that the information provided on this form is current and valid. I am responsible for payment in accordance with my insurance policy and the policy as stated at: [www.piperfamilymedicine.com](http://www.piperfamilymedicine.com) or will be provided with a copy by request.

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Patient/Legal Guardian Signature \_\_\_\_\_

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Date \_\_\_\_\_