Well Primary Care
Patient Registration

Patient Information		
Name:		Date of birth: / /
I prefer to be addressed as:		Gender:
Email:		
Cell phone: ( )	Home: ( )	Work: ( )
Home Address:	City:	State: Zip:
I authorize Well primary care to email me regarding my medical care: [ ] Yes [ ] No Initials:		
Allergies, including reaction:		
Preferred Pharmacies - Local:		Mail Order:
Emergency Contact Name:		Relation to you:
Emergency Contact Phone:		

Insurance Information
Although we do not submit claims to your insurer, we may need this information to assist you with referrals or prior authorizations. Please bring your insurance card to your first appointment so that we may scan it to your record. Thank you.

Optional Information		
Ethnicity:	Race:	[ ] Veteran
It is the policy of Well Primary Care to not discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity, gender expression, or disability.		

If you are enrolling other family members in your household, please see back →

WELL Primary Care, LLC
Patient Registration - Additional Family Members

Name:	Date of birth: / /
Address: same as above [ ]	
Relation to you:	
Email:	Cell:
Allergies:	
(Optional) Gender: Ethnicity:	Race: [ ] Veteran

Name:	Date of birth: / /
Address: same as above [ ]	
Relation to you:	
Email:	Cell:
Allergies:	
(Optional) Gender: Ethnicity:	Race: [ ] Veteran

Name:	Date of birth: / /
Address: same as above [ ]	
Relation to you:	
Email:	Cell:
Allergies:	
(Optional) Gender: Ethnicity:	Race: [ ] Veteran