NEXTGEN
MALE MEDICAL CLINIC
CHANGING THE FUTURE OF MEN'S HEALTH & WELLNESS

Patient Registration Information

Patient Name: _____
Last First Middle

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Can we contact you by: ☐ Email / ☐ Text Message / ☐ Phone

Sex: ☐ Male / ☐ Female Date of Birth: ____/____/____ Social Security #: ___ – ___ – ____

How did you hear about us? ☐ Referral / ☐ Internet / ☐ Radio: _____

Marital Status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Widowed / ☐ Other

Ethnicity/Race: _____ Primary Care Physician: _____

Employment Status: ☐ Full Time / ☐ Part Time / ☐ Retired / ☐ Disabled / ☐ Other

Patient's Employer: _____

Employer Phone #: _____ Employer Address: _____

Emergency Contact: _____
Name Phone Relationship

Primary Insurance

Primary Insurance Company: _____

Claims Address: _____
(On Back of the Card)

Subscriber's Name: _____ Member ID #: _____

Group Name: _____ Group Number: _____

Patient Relationship to Subscriber: ☐ Self / ☐ Spouse / ☐ Child / ☐ Other

If spouse or other party is the insurance subscriber, please provide the following:

Name: _____ Date of Birth: ____/____/____

Employer: _____

Do you have secondary insurance? ☐ Yes / ☐ No

Secondary Insurance

Insurance Company: _____

Claims Address: _____
(On Back of the Card)

Subscriber's Name: _____ Member ID #: _____

Group Name: _____ Group Number: _____

Patient Relationship to Subscriber: ☐ Self / ☐ Spouse / ☐ Child / ☐ Other

If spouse or other party is the insurance subscriber, please provide the following:

Name: _____ Date of Birth: ____/____/____

Employer: _____

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