

Ridge Family Practice, P.C.

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• Alan J. Pokorski, P.A. • Christy M. Quillen, A.R.N.P • Tammy L. Hunke P.A.-C.

Patient Registration

Patient Information

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ SSN: ____ - ____ - ____ Sex: M F

E-mail Address: _____ Marital Status: S M W D

Address: _____ City: _____ State: _____

Zip: _____ Primary Phone: _____ Alternate Phone: _____

Spouse Information

Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____

Zip: _____ Primary Phone: _____ Alternate Phone: _____

Emergency Contact Information:

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Alternate Phone: _____

Race

- Caucasian African American
 Hispanic Asian
 Other(please specify) _____

Ethnicity

- Hispanic or Latino
 Not Hispanic or Latino
 Unknown/Unreported

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Main Office
201 Ridge St. #201
Council Bluffs, IA 51503
Phone: (712)322-5899
Fax: (712)322-5730

Minden Office
401 Broadway
Minden, IA 51553
Phone: (712)483-2077
Fax: (712)483-5638

Treynor Office
31 East Main
Treynor, IA 51575
Phone: (712)487-3636
Fax: (712)487-3737

Primary Language

- English Spanish Chinese French German Japanese
- Korean Deaf Services Multiple Languages Sign Languages
- Unknown/Unreported Other (please specify) _____

Employment Information:

Employer: _____ Address: _____ City: _____
 State: _____ Zip: _____ Phone: _____

Financial Information:

Primary Insurance: _____ Secondary Insurance: _____ N/A

Name of Primary Insurance Holder: _____

SSN: ____ - ____ - ____ Birth Date: _____

Name of Secondary Insurance Holder: _____

SSN: ____ - ____ - ____ Birth Date: _____

Primary Method of Payment: Cash Credit Card Check

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

** Failure to meet the co-pay obligations at the time of service, as required by your insurance carrier, will result in a \$10.00 co-pay rebilling fee.*

*** I understand that by signing this form I agree that I am financially responsible for any balance incurred for services provided to me or my dependants. All past due balances will be charged a 1.5% service fee. All balances over 120 days old will be turned over to an outside collection agency.*