Nanbo Guahan 250 Building Suite 203 Route 4 Hagatna, Guam 96910
Telephone: (671) 475-6500 Fax: (671) 475-6520 Website: www.hagatnamed.com

PATIENT DEMOGRAPHICS

PATIENT REGISTRATION DATE:

Name: ______________________________ **Date of Birth:** ________________ **Age:** ____________
Last Name First Name Middle initial Month Day Year

Social Security #: ________________________ **Gender:** Male / Female **Marital Status:** S / M / D / W

Mailing Address: ____

City: ____________________ **State:** ________________ **Zip Code:** ____________________

Email Address: ____

Home Phone #: ______________ **Work Phone #:** ______________ **Cell Phone:** ______________

Employer: ____________________________ **Primary Physician:** ____________________________

Preferred Pharmacy: ____

PERSON RESPONSIBLE FOR ACCOUNT (SUBSCRIBER) Email:

Name: ____________________________________ **Date of Birth:** ____________________
Last Name First Name Middle Initial Month Day Year

Social Security #: ____________________________ **Relationship to Patient:** ____________________

Mailing Address: ____

City: ____________________ **State:** ____________________ **Zip Code:** ____________________

Home Phone #: ______________ **Work Phone #:** ________________ **Cell Phone:** ______________

Employer: ____________________________**Occupation:** ____________________________

EMERGENCY CONTACT INFORMATION - Email address:

Name: ____________________________________**Relationship to Patient:** ____________________
Last Name First Name Middle initial

Home Phone #: ____________ **Work Phone #:** ________________ **Cell Phone:** ________________

PRIMARY INSURANCE / SELF PAY

Insurance Company: ____________________________**Policy No:** ____________________________

Coverage: ____________________________________**Subscriber:** ____________________________
(If Off-island insurance company, please provide information below as accurately as possible)

Address: ______________________**City:** ____________ **State:** __________ **Zip Code:** __________

SECONDARY INSURANCE

Insurance Company: ____________________________________Policy **#:** ____________________________

Coverage: ____________________________**Subscriber:**____________________________________
(If Off-island insurance company, please provide information below as accurately as possible)
Address: ______________________ **City:** ____________ **State:** __________ **Zip Code:** __________