

CAPITAL PRIMARY CARE, INC.  
ADULT PATIENT REGISTRATION  
Ages 18 and Over  
(Please Print)

PATIENT INFORMATION

Last Name	First Name / MI	Date of Birth	Sex F ___ M ___	Social Security Number
Home Address		City		State
Home Phone Number		Cell Phone Number		Email Address
Preferred Telephone Contact		May we leave confidential message? Y__ N__ May we email confidential Info? Y__ N__		

PATIENT EMPLOYMENT INFORMATION

Name of Employer	Occupation / Indicate if Student	Business Phone Number	
Employer Street Address		City	State
			Zip Code

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone Number

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Insurance Name _____ Policy / ID _____ Group / Plan _____ Insurance Effective Date _____ Policy Holder Name _____ Employer _____ Policy Holder SSN/DOB _____ Relationship to Patient _____	Insurance Name _____ Policy / ID _____ Group / Plan _____ Insurance Effective Date _____ Policy Holder Name _____ Employer _____ Policy Holder SSN/DOB _____ Relationship to Patient _____
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How did you hear about us? Internet  Personal Reference  If so, who? \_\_\_\_\_ Other  \_\_\_\_\_

**Assignment and Release:** I authorize my insurance benefits be paid directly to Christian N. Nwankwo, M.D. I also authorize the physician to release any information required in processing this claim. I further authorize you to release to my insurance company or their agents, information concerning healthcare, treatment, advice, and supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Date

**Privacy Practices:** I acknowledge that I have received notice of Capital Primary Care, Inc's Privacy Practices for any services furnished me by its physicians. I hereby acknowledge that I am financially responsible for any deductibles, co-payments and other non-covered charges resulting from my visits and services provided by this medical practice.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Date