ST. JOHNS MEDICAL GROUP
PATIENT REGISTRATION

Family Health & Urgent Care
James Little Jr., MD
Jennifer Fritch, PA
Cecelia Tramburg, FNP-C
Layne Lash, FNP
Christian Dean, DO
Kim Mellick, NP
Emily E Johnston, MD
Berit Amundson, MD

Cognitive Health
Martha Stearn, MD

Internal Medicine
Calvin Schenk, PA
Tierney Lake, MD
Sarah Peterson, RD

Ear, Nose & Throat
Martin Trott, MD
Jennfer Almond, PA

Audiology
Rosanne Prince, Au.D.

Internal Medicine Wilson
Michael Menolascino, MD
Christine Turner, MD
Tessa J Enright, FNP-BC

General Surgery
Michael Rosenberg, MD
Randy Kjorstad, MD
Eric Wieman, MD

Plastic & Reconstructive Surgery
John Payne, DO

Cardiology
William Mullen, DO

Urology
Lisa Finkelstein, DO

Witness Initials
_____

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (mm/dd/yyyy): _____ Social Security Number: _____

Sex (circle one): Male Female Marital Status (circle one): Single Married Divorced Widowed

Responsible Party (if different than patient):

Responsible Party (First & Last Name): _____ Relationship to Patient: _____

Address: _____ Phone_____

City: _____ State: _____ Zip: _____

Date of Birth (mm/dd/yyyy): _____ Social Security Number: _____

Demographics:

Billing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary Care Physician: _____ Referring Physician: _____

How would you prefer to be reminded of upcoming appointments? (circle one): Home Phone Cell Phone Text

Do we have your permission to leave voice mails on phone numbers provided? (circle one): Yes No

Would you like to be able to access your medical records through our online Patient Portal? (circle one): Yes No

Emergency Contact Information:

First/Last Name: _____ Relation: _____Phone: _____

Patient Race (circle one): American Indian/Alaskan Asian Black/African American White Other: _____

Patient Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino Refuse to Respond Other: _____

Primary Language (circle one): English Spanish Other: _____

Is the purpose of your visit today a work related injury? (circle one): Yes No If yes, Date of Injury: _____

Preferred Pharmacy (circle one): Albertson's (Sav-On) Smiths Stone Drug

Other, Please list Pharmacy Name and Location: _____

Employer: _____ Phone Number: _____

Primary Insurance Company: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Policy ID Number: _____ Policy Group Number: _____

Insured Name: _____ Relation to Patient: _____

Insured Social Security Number: _____ Insured Date of Birth: _____

Secondary Insurance Company: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Policy ID Number: _____ Policy Group Number: _____

Insured Name: _____ Relation to Patient: _____

Insured Social Security Number: _____ Insured Date of Birth: _____

I accept full responsibility for the above named patient or myself and agree to all charges for services rendered.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____