



**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**

Dennis Butcher, MD

Hayley Miller, MD

Calvin Schenk, PA

Tierney Lake, MD

Sarah Peterson, RD

**Ear, Nose & Throat**

Martin Trott, MD

Jennifer 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

**Other**

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 Kmart 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:** \_\_\_\_\_