Srirengam Muralidhasan, M.D. LLC
1605 El Paseo Rd, Las Cruces NM 88001
P: 575-523-5400 F: 877-539-2504

Today's Date _____/_____/_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	○ Mr ○ Mrs ○ Miss ○ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ○ YES ○ NO	If not, what is your legal name?		Birthdate / /	Age Sex ○ M ○ F ○ T
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status: ○F – Full-Time Student ○P – Part-Time Student ○N – Not a Student

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____

Pharmacy: Do you have a living will? ○ YES ○ NO

Referred By (Please check one box)
☐Dr. _____ ☐Insurance ☐Hospital ☐Family ☐Friend ☐Yellow Pages ☐ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: ○Another Patient ○Guarantor ○Self ☐Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )

Occupation	Employer	Employer Address	Employer Phone Number
			( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐WORKERS COMPENSATION (WC)
☐OCCUPATIONAL MEDICINE (OM) ☐MOTOR VEHICLE ACCIDENT (MVA) ☐ACCIDENT DATE _____

Does the patient have healthcare coverage? ☐ YES ☐ NO **Insurance Name**

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)
	- -	/ /	/ /		

Patient Relationship to Insured ○Self ○Spouse ○Child ○Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)
		/ /		

Patient Relationship to Insured ○Self ○Spouse ○Child ○Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number
		( )	( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____
Patient/ Guardian Signature Date