LOGAN UNIVERSITY

HEALTH CENTERS

New Patient Registration

First Name: _____ Initial: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Home Phone: (____)_____ Work Phone:(____)_____ Cell Phone:(____)_____

Gender: □ Male □ Female **Marital Status:** □ Single □ Married □ Divorced □ Widowed

Race (Select one or more):

□ White
□ Black/African American
□ Hispanic or Latino
□ American Indian/Alaskan Native
□ Native Hawaiian/Other Islander
□ Asian
□ I do not wish to specify

Ethnicity (Check one):

□ Hispanic or Latino □ Neither Hispanic or Latino □ I do not wish to specify

Work Status (Check one): □ Employed □ Retired □ P/T Student □ F/T Student □ Unemployed

Insurance Information:

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Patient's relationship to subscriber: _____

Person responsible for payment if other than above:

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____

Emergency Contact Information:

First Name:_____ Last Name:_____ _____

Phone Number:(____)_____ Relationship: _____

Patient Portal:

In efforts to provide you with the best healthcare experience, we are offering ***access to your medical records as well as online scheduling*** through a confidential Patient Portal.

Instructions with initial sign in information will be emailed upon registration today.

Please provide an email for your patient portal access: _____

Chesterfield Location
Montgomery Health Center
636-230-1990

St. Peters Location
Mid Rivers Health Center
636-397-3545

Updated: April 2019