FORD –TEL MEDICAL CENTER
23800 FORD ROAD
DEARBORN HEIGHTS, MI 48127
(313) 274-8181

PATIENT REGISTRATION

Patient Name:_____

Sex: MALE FEMALE **Social Security No**:

Responsible party (if minor): **Relationship to Pt:**

Street Address: **Date Of Birth:**

City/State: **Zip:** **Tel. No:**

Referred By: **Marital Status:** S M W D

Pharmacy Name & Address:

Pharmacy Tel. No:

Your e-mail:

PATIENT EMPLOYER INFORMATION

Employer Name: **Tel No:**

Employer Street Address: **City/State/Zip:**

EMERGENCY CONTACT

Name: Tel No:

INSURANCE INFORMATION

**** Please submit insurance card(s) to receptionist for copying****

Indicate relationship to insured:

Do you have an advanced directive and/or living will? YES NO