CIMA

The Kane Clinics, LLC.

Patient Registration

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Sex:** _____ **Social Security #** _____

Race: _____ **Ethnicity:** _____ **Primary Language:** _____

Marital Status: _____ **Preferred Pharmacy:** _____

Address: _____ **Apt:** _____

Zip Code: _____ **City:** _____ **County:** _____ **Country:** _____

Phones

Home: _____ **Work:** _____ **Cell:** _____ **Primary:** _____

E-mail: _____ **Preferred Communication:** _____

Emergency Contact

Name: _____ **Phone #** _____ **Relationship:** _____

Name: _____ **Phone #** _____ **Relationship:** _____

Insurance

Company: _____ **Plan Name:** _____

Policy #: _____ **Group #:** _____

How did you hear about us?

- ☐ CIMA website
- ☐ Facebook
- ☐ Flyer
- ☐ Friend
- ☐ Health Fair
- ☐ Insurance
- ☐ Internet
- ☐ Mundo Hispanico
- ☐ Newspaper
- ☐ Other Practice referral
- ☐ Postcard
- ☐ Previous Patient
- ☐ Que Pasa en Atlanta
- ☐ Radio Program
- ☐ Social Media
- ☐ Taxi
- ☐ Television Commercial
- ☐ Twitter
- ☐ Zoc Doc
- ☐ Other*

*** Please elaborate:** _____

I understand the cost for my prenatal care and agree to pay this amount to Centro Internacional de Maternidad (CIMA)

Signature: _____ Date: _____

02/18