Patient Registration Form (eCW)

PATIENT INFORMATION

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last)__________________________ (First)______________(MI)______ Previous Name________________________

Address, City, State, ZIP____

Home Phone ________________________ Cell No. ____________________ Work Phone _____________________ Ext. __________

Primary Care Provider (PCP) ____ Referring Provider _______________________________

Rendering Provider Name (this practice) ______________________________ Date of Birth MM______/DD ______/YYYY___________

E-Mail Address ____ Permission to Contact via Email Yes No

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 Sex F-Female M-Male Transgender

Language English Spanish Indian Japanese Chinese Korean French German Russian Other ______________

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number _______-_____-_______ Employer Name____

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

Emergency Contact Name____ Phone Number____________________________

Emergency Contact Relationship to Patient________________________________ Guardian

Address Line 1 ____

City, State, ZIP ____ Do you have a living will? Yes No

Home Phone ________________________ Work Phone _____________________ Ext. ______

Referring Provider Name____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party Another Patient Guarantor Self **Check here if information is same as patient**

Responsible Party Name (Last)___________________________ (First)______________________________ (MI) __________

Guarantor Account Number ___________________________ Date of Birth MM ________/DD ________/YYYY___________

Social Security Number _______-_____-_______ Telephone ________________________ Sex F - Female M - Male

E-Mail Address ____ Permission to Contact via Email Y N

Address, City, State, ZIP ____

Employer____ Employer Phone Number____________________________

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

Insurance Company/Phone Number______________________________ (______)____

Name of Insured____ Patient Relationship to Insured______________________

Subscriber ID (Policy Number)___________________ Group ID___________________ Copay Amount______________________

Effective Date______________________Termination Date_________________ Date of Birth MM______/DD ______/YYYY______

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

Insurance Company/Phone Number____ (______)_________________

Name of Insured____ Patient Relationship to Insured______________________

Subscriber ID (Policy Number)___________________ Group ID___________________ Copay Amount______________________

Effective Date______________________Termination Date_________________ Date of Birth MM______/DD ______/YYYY______

HOW DID YOU LEARN ABOUT US? (check all that apply)

Referring Provider	Website	HealthGrades.com	Other
Family/Friends	Blog	Vitals.com	
Search Engine	Facebook	Yelp.com	
Physician Directory	Twitter	Google Places Page	

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

Patient (or Responsible Party) Signature____ ***Date***_________________

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