

# PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: \_\_\_\_\_  
(Street) (City/State/Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Would you be interested in having communications sent to you via your e-mail address? (examples: appointment reminders, administrative updates and health bulletins) Yes No

Employer Name: \_\_\_\_\_ Employer Phone Number: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City/State/Zip)

Primary Care Physician: \_\_\_\_\_ Copay Amount \$ \_\_\_\_\_  
(Name)

How did you hear about our Practice? \_\_\_\_\_

## Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone Number: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City/Street)

## Who to call for an emergency:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

## FIRST INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

## SECOND INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

## THIRD INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

**IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?** Y \_\_\_\_ N \_\_\_\_

**IF YES, PLEASE NOTIFY THE RECEPTIONIST**

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Northeast Health. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_