Patient Registration Form (eCW)

(Please Print) \square Dr. \square Miss \square Mr. \square Mrs. \square Ms. \square Sir Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name ____ Address Line 1 ZIP______ Pharmacy_____Pharmacy Phone City, State Home Phone ______ Cell No. _____ Work Phone _____Ext. ____ Primary Care Provider (PCP) _ Referring Provider Rendering Provider Name (this practice) ______ E-Mail Address:_____ MM _____/DD _____/YYYY _____ Sex \square F – Female \square M - Male Transgender Race American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined Ethnicity Hispanic or Latino Not Hispanic or Latino Declined Language English Spanish Indian Japanese Chinese Korean French German Russian Other Married Single Divorced Widowed Legally Separated Partner Marital Status _____-___Employer Name _____ Social Security Number Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military F - Full-Time Student P - Part-Time Student N - Not a Student Emergency Contact Last Name _____ First Name _____ _____ Do you have a living will? Phone Number Guardian Emergency Contact Relationship to Patient Address Line 1 _____ ZIP_____ City, State 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) _____ _____ Date of Birth MM /DD /YYYY Guarantor Account Number Social Security Number - - Telephone Sex \square F – Female \square M - Male E -Mail Address Address Line 1 ZIP City, State 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)_____ Copay Amount Group ID Termination Date Date of Birth MM /DD /YYYY Effective Date 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 ______ Termination Date______Date of Birth MM _____/DD _____ /YYYY Effective Date I agree that the information supplied on this form is accurate and up-to-date to the best of mv knowledge. Patient (or Responsible Party) Signature_____ Date___

PATIENT INFORMATION