

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: _____