

PATIENT REGISTRATION

Today's Date _____ Home Phone # _____ - _____ - _____ Cell Phone # _____ - _____ - _____

Patient's Last Name _____ First _____ Middle Initial _____

SS # _____ - _____ - _____ Date of Birth _____ / _____ / _____ Male or Female Status: S M D W

Home Address _____ Apartment Number _____

City _____ State _____ Zip Code _____ Email address: _____

Occupation _____ Employer Name _____

Employer Address _____ City _____ State _____ Zip Code _____

Work Phone # _____ - _____ - _____ Emergency Contact _____

Emergency Phone # _____ - _____ - _____ Relationship to Patient _____

Referred By _____ Primary Care Physician _____

How did you hear about us? Advertisement Employer Friend/Relative Other: _____

PRIMARY INSURANCE Subscriber to Insurance: Self Spouse Parent Company

Last Name _____ First _____ Middle _____

Relationship to Patient _____ SS # _____ - _____ - _____ Date of Birth _____

Insurance Name _____ Subscriber ID _____ Group # _____

Insurance Address _____ Phone # _____ - _____ - _____

City _____ State _____ Zip Code _____

SECONDARY INSURANCE Subscriber to Insurance: Self Spouse Parent Company

Last Name _____ First _____ Middle _____

Relationship to Patient _____ SS # _____ - _____ - _____ Date of Birth _____

Insurance Name _____ Subscriber ID _____ Group # _____

Insurance Address _____ Phone # _____ - _____ - _____

City _____ State _____ Zip Code _____

WORKERS COMPENSATION Did you report the injury to your Employer? Yes No

Date of Injury _____ / _____ / _____ Time: _____ AM/PM Claim Number _____

Where Injury Occurred _____

Employer Contact _____ Contact Phone # _____ - _____ - _____

Claims Adjuster _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____

Insurance _____ Address _____

City _____ State _____ Zip Code _____

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying Washington Township Medical Foundation of any changes made to my contact information and/or insurance.

Medication History Consent: I hereby authorize Washington Township Medical Foundation (WTMF) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice. I authorize WTMF to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

DATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY