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: _____
PCN-100 (Rev.10/30/00)