BOONE'S CREEK MEDICAL

Patient Registration Form

PATIENT NAME: _____ DATE:_____/_____/_____
(last) (first) (mi)

ADDRESS: _____ HOME PHONE: _____

CITY,STATE:_____ CELL OR WORK PHONE:_____

BIRTHDAY: _____/_____/_____ SOCIAL SECURITY #: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEX: M F

PATIENT'S EMPLOYER: _____ FULL-TIME or PART-TIME

EMAIL ADDRESS_____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

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INSURANCE INFORMATION (Fill out if Responsible Party other than the patient)

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

INSURED'S NAME: _____ INSURED'S NAME: _____

DOB: ____/____/____ SS# _____ DOB: ____/____/____ SS#: _____

RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____ INSURED'S EMPLOYER: _____

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EMERGENCY CONTACT

WHO MAY WE CONTACT IN CASE OF EMERGENCY? _____

RELATIONSHIP: _____ PHONE: _____

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WHO MAY WE RELEASE PHI (PERSONAL HEALTH INFORMATION) TOO?

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