Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

Patient's Name (Last)__________________ (First) __________________ (MI)____ Previous Name__________________

Address ____

City, State ____ ZIP ______________

Home Phone _________________ Cell No. __________________ Work Phone_________________ Ext.________

Primary Care Provider (PCP) _______________________________ Referred By_________________________

E-Mail Address ____

Date of Birth MM___________/DD_____________/YYYY_________ Sex ☐ F-Female ☐ M-Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other __________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Employer Name____

Employment Status ☐ 1 – Full-Time ☐ 2 – Part-Time ☐ 3 – Not Employed ☐ 4 – Self-Employed ☐ 5 – Retired ☐ 6 – Active Military

Student Status ☐ F – Full-Time Student ☐ P – Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name_______________________________ First Name_________________________

Phone Number _______________________________________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _______________________________________ ☐ Guardian

Home Phone ____________________________________ Work Phone_________________ Ext.________

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) __________________________ (MI)________

Guarantor Account Number ___________________________ Date of Birth MM________/DD________/YYYY________

Social Security Number ___________________________ Telephone ___________________________

E-Mail Address ____ Sex ☐ F - Female ☐ M - Male

Address Line 1 ____

City, State ______________________________ ZIP ______________

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) ____________________ Group ID ________________ Copay Amount ____________

Effective Date __________________ Termination Date ______________ Date of Birth MM_____/DD_____/YYYY______

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 ____________

Effective Date __________________ Termination Date ______________ Date of Birth MM_____/DD_____/YYYY______

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Legal Guardian) Signature ____ ***Date***______________