JW Family Medicine

REGISTRATION FORM – PATIENT PROFILE

Today's Date:		Received by:		Entered by:	
PATIENT INFORMATION					
Patient's last name: First:		Middle:		Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security #:	Home phone # – Cell phone #		E-Mail		
Occupation:	Employer:		Employer phone #:		
Chose clinic because/referred to clinic by:	○ Referring Physician _____				
	◉ Primary Care Physician _____				
Other family members seen here:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:		Other:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:			| Other:		
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
IN CASE OF EMERGENCY					
Name of local friend or relative:		Relationship to patient:	Home phone #:	Work phone #:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and/or JW Family Medicine. I understand that I am financially responsible for any balance. I also authorize JW Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____