Patient Registration Form (eCW)

PATIENT INFORMATION			(Please Print	
☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ M	s. Sir			
		(MI) F	Previous Name	
Address Line 1				
City, State				
			Pharmacy Phone	
			oneExt	
			Phone	
Referring Doctor	Address		Phone	
Doctor you are seeing at this facility?		E-Mail A	address	
Date of Birth MM/DD	/YYYY	Sex □ F	– Female	
_			☐ Black or African American ☐ White ☐	
Declined				
Ethnicity Hispanic or Latino Not	Hispanic or Latino Declined			
Language English Spanish	Indian Japanese Chinese	e ☐ Korean ☐ Fren	ch German Russian Other	
Marital Status	e Divorced Widowed	Legally Separate	ed Partner	
<u>- </u>		-	ployed 5 - Retired 6 - Active Military	
	udent P - Part-Time Student			
Do you have a living will? Yes	_	IN - Not a Staden	•	
EMERGENCY CONTACT INFORMATION	□ INO			
		Firet	Nama	
		First Name Guardian		
			🗀 Guardian	
Address Line 1			ne	
Cell Phone			Ext	
PRIMARY INSURANCE INFORMATION	Work i none		e your insurance card to the front desk at check-in	
TRIMART INSURANCE IN ORMATION		(provide	e your insurance card to the north desk at theth-in	
Auto related? \square Yes \square No (If yes, p	lease see receptionist for additiona	ıl form)		
Work related? \square Yes \square No (If yes,	please see receptionist for addition	al form)		
Insurance Company/Phone Number			()	
Name of Policy Holder:			onship to policy Holder:	
Social Security Number of Policy Holder	·	Date of Birth M	M _/DD/YYYY	
Subscriber ID (Policy Number)	Group ID		Copay Amount	
Effective Date	Termination Date			
SECONDARY INSURANCE INFORMATION		(provide	e your insurance card to the front desk at check-in	
Insurance Company/Phone Number_			()	
Name of Policy Holder:			onship to policy Holder:	
			M _/DD/YYYY	
			Copay Amount	
Effective Date			· ·	
I agree that the information supplied on	·		ny knowledge.	
Patient (or Responsible Party) Signat	ure		Date	

AUTHORIZATION

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