

Date: _____

PATIENT REGISTRATION FORM

PLEASE PRINT & COMPLETE IN FULL

Account # _____

Physician's Name: Kenneth Aldridge, M.D. Howard Winfield, M.D.
Mrinal Dhar, M.D. Matthew Thom, M.D.

PATIENT INFORMATION

SOCIAL SECURITY #: _____ - _____ - _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: (circle) Female or Male

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

RACE: AFRICAN AMERICAN ASIAN CAUCASIAN HISPANIC NATIVE AMERICAN OTHER:

IF PATIENT IS A CHILD, LIVES WITH: BOTH PARENTS MOTHER FATHER OTHER:

NAME OF PERSON (WITH WHOM CHILD LIVES WITH) _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

SOCIAL SECURITY # _____ - _____ - _____

RESPONSIBLE PARTY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____

DATE OF BIRTH: ____/____/____ SEX: (circle) Female or Male RELATIONSHIP: _____

RESPONSIBLE PARTY EMPLOYER: _____

PATIENT EMPLOYER INFORMATION

EMPLOYED: Y or N FULL-TIME STUDENT _____ PART-TIME STUDENT _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAIN OFFICE PHONE: () _____ - _____ OCCUPATION: _____

Scheduled working hours: _____ STANDARD (M-F, 8-5) _____ OTHER: _____

INSURANCE INFORMATION (WE REQUIRE A COPY OF YOUR CARD)

PRIMARY INSURANCE : _____ COPAY: Y or N AMOUNT: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: ____/____/____ PERCENTAGE PLAN PAYS (example: 80%) _____

INSURANCE ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE () _____ - _____

IF INSURANCE IS THROUGH AN EMPLOYER, GIVE EMPLOYER NAME: _____

POLICY NUMBER : _____ GROUP NUMBER: _____

(More on back)

SECONDARY INSURANCE: _____ COPAY: Y or N AMOUNT: _____
POLICY HOLDER NAME: _____ RELATIONSHIP: _____
DATE OF BIRTH: ____ / ____ / ____ PERCENTAGE PLAN PAYS (example: 80%) _____
INSURANCE ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ PHONE (____) _____ - _____
IF INSURANCE IS THROUGH AN EMPLOYER, GIVE EMPLOYER NAME: _____

POLICY NUMBER : _____ GROUP NUMBER: _____

THIRD INSURANCE: _____ COPAY: Y or N AMOUNT _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: ____ / ____ / ____ PERCENTAGE PLAN PAYS (example: 80%) _____

INSURANCE ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE (____) _____ - _____

IF INSURANCE IS THROUGH AN EMPLOYER, GIVE EMPLOYER NAME: _____

POLICY NUMBER : _____ GROUP NUMBER: _____

REFERRED BY

REFERRING PHYSICIAN: _____ PHONE (____) _____ - _____

If not referred by a physician, how did you hear about our office: (check one)

- WEB PAGE YELLOW PAGE FRIEND/FAMILY RADIO INSURANCE DIRECTORY
 TV EMERGENCY ROOM VISIT NEWSPAPER OTHER:

PRIMARY CARE PHYSICIAN NAME (if different from above):

PHONE (____) _____ - _____

IN CASE OF EMERGENCY:

RELATIVE/FRIEND: _____

HOME PHONE: (____) _____ - _____ WORK PHONE: (____) _____ - _____

RELATIONSHIP: _____

EMERGENCY CONTACT THAT DOES NOT LIVE IN HOUSEHOLD:

NAME: _____

HOME PHONE: (____) _____ - _____ WORK PHONE: (____) _____ - _____

RELATIONSHIP: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHONE (____) _____ - _____