WHITSONvision
Medical • Surgical • Research

Patient Registration Form

(Please complete both sides)

PATIENT INFORMATION

Patient Name ______________________________ Date: __________
Last First Middle

Date of Birth__________ Age ______ Gender ___F_____M____Social Security # ______________

Address ____
Street City State Zip

E-mail address____________________________________

Home Phone (_____) __________ Work Phone (_____) __________ Cell Phone (_____) __________

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated ___ Child

*If patient is a minor, lives with*______________________ *Relationship*__________

Employed ___ Occupation ______________ Retired ___ Full time Student ___ Part time Student___

Employer ______________ Phone (_______)______________

SPOUSE INFORMATION

Spouse's Name ______________ Social Security __________ Birth Date __________

Spouse's Employer ______________________ Phone (_______)__________

RESPONSIBLE PARTY: IF OTHER THAN PATIENT

Name ______________________ Relationship to Patient______________

Address (if other than above) ______________________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Responsible Party's Birthday ____________ Social Security # ______________

Employer ______________ Address ______________________

EMERGENCY CONTACT: NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU

Name ______________________ Relationship to Patient ______________

Address (if other than above) ______________________ Phone ______________

PRIMARY INSURANCE INFORMATION SECONDARY

Company Name ______________ Company Name ______________

Subscriber's Name ______________ Subscriber's Name ______________

Subscriber's date of birth ______________ Subscriber's date of birth ______________

Subscriber's SS# ______________ Subscriber's SS# ______________

Policy ID# ______________ Policy ID# ______________

(Complete the back side)

ARE YOU SEEKING TREATMENT DUE TO AN ACCIDENT OR INJURY?

Were you injured at Work? ____ yes ____ no Is this covered by Worker's Compensation? ____ yes ____ no

If Yes, Contact person at your Employer ____

Date & Time of Accident ______________________ Place of Accident ______________________

How did the injury happen? ____

____

Name of Physician who treated you at the time of accident ______________________________

FINANCIAL RESPONSIBILITY/RELEASE OF INFORMATION AUTHORIZATION

I herby give consent to the attending physician to release any medical information necessary to my insurance company and the payment of benefits to the Physician for services received. I also authorize the release of information to listed physician and/or individuals. I understand that this consent remains valid unless/until I revoke it myself.

Patient Signature______________________________________ Date ______________________
Or Legal Guardian

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist in the responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my insurance company and physician, HMO, or other managed entity. If for any reason the account should become delinquent, I am liable to pay for collection and attorney fees.

Patient Signature______________________________________ Date ______________________
Or Legal Guardian