



PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ Ext. _____

E-Mail Address: _____

Date of birth: MM ____ /DD ____ /YYYY ____

Sex: Female Male Transgender

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander
 Black/African American White Hispanic Other Declined
Language: English Spanish Indian Japanese Chinese Korean
 French German Russian Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Marital Status: Married Single Divorced Widowed Legally Separated Partner

Social Security Number: _____ - _____ - _____ 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

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM ____ /DD ____ /YYYY ____ Sex: Female Male

Social Security Number: _____ - _____ - _____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____ E-mail Address: _____

Employer: _____ Employer Phone Number: _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? Yes No

Emergency contact relationship to patient: _____ Guardian

Address: _____

City, State: _____ ZIP: _____

Home phone: _____ Work phone: _____ Ext. _____

PRIMARY INSURANCE INFORMATION

(Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in)

Insurance Company: _____ Phone Number: (____) _____

Name of Insured: _____

Patient Relationship to Insured: _____ Date of Birth: MM ____ /DD ____ /YYYY ____

Subscriber ID (Policy Number): _____ Group ID: _____ Copay Amount: _____

Effective Date: _____ Termination Date: _____

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: _____ Date of Birth: MM ____/DD ____/YYYY ____
Subscriber ID (Policy Number): _____ Group ID: _____ Copay Amount: _____
Effective Date: _____ Termination Date: _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____