REGISTRATION

Date:______________________________

Patient Primary Care Physician:______________________________

Dalewod Medical Center

How did you hear about us?______________________________

____

Patient Information:

PATIENT LAST NAME:____________________________ FIRST:______________________________ MIDDLE:___________

If Minor, Person Responsible For Patient and Charges____

Responsible Party DOB:__________________________ Responsible Party Social Security No.____________________

atient Birthdate:___________________________ Sex:_________ Patient Social Security No.:_______________________

ace:________________________ Ethnicity:_________________________ Language: _______________________________

Address:_________________________________ City:___________________________ State:_________ Zip Code:______

Home Phone:________________________ Cell Phone:________________________ Work Phone:___________________

Employer:_________________________________ Marital Status:___________ Email:_______________________________

Emergency Contact Name:_______________________________ Phone:____________________ Relationship:_________

Preferred Pharmacy:_____________________________________ Pharmacy Street:_______________________________

Pharmacy City and State:________________________________ Pharmacy Phone:________________________________

Primary Insurance Company Name:

Subscriber's Name:____ Subscriber Birthdate:___________________________

Relationship to Patient:_______________________________ Subscriber's Employer_______________________________

Social Security No. of Subscriber:_______________________________________

Secondary Insurance Company Name:

Subscriber's Name:____ Subscriber Birthdate:___________________________

Relationship to Patient:_______________________________ Subscriber's Employer_______________________________

Social Security No. of Subscriber:_______________________________________

The above information is true to the best of my knowledge. I consent to treatment and tests by Dalewood Medical Center providers and staff. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dalewood Medical Center or Insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____________________________________Date:_____________________

Printed Patient/Guardian Name:________________________________