

REGISTRATION FORM

PATIENT INFORMATION							
Last Name		First Name		Middle Initial		Maiden Name	
Address				City/State		Zip	
DOB	Age	Relation to Responsible Party		SS#	Home Phone		Work Phone
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Employer Name & Address			Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed		Cell Phone	
				E-Mail Address			
Primary Care Physician			Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Patient Student Status <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Not a Student		
Name of siblings or other family members also coming to this practice:							
How did you hear about us? <input type="checkbox"/> Hospital Help Line <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Provider Directory <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor							
Other: Name: _____				May we thank them? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<input type="checkbox"/> SAME AS PATIENT		RESPONSIBLE PARTY INFORMATION (If Different from Patient)				
<i>Person who accompanies child to visit</i>						
Last Name		First Name		Middle Initial		
				Maiden Name		
Birthdate						
Address		S.S.#		Home Phone		
				Cell Phone		
Work Phone						
City, State, Zip		Relationship to Patient		Employer Name & Address		
Spouse		Spouse Employer & Address			Spouse Work Phone	

EMERGENCY CONTACT (nearest relative not living with you)		
Emergency Contact Name		Home Phone
		Work Phone
Address, City, State & Zip		Other Phone
		Relation to Patient

PRIMARY INSURANCE INFORMATION				
Insurance Company		Group#/Plan ID	Member Number	Copay Amount
				Effective Date
Subscriber Employer Name & Address		Patient Relationship to Insured:	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name & Address		Does your insurance require a referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

SECONDARY INSURANCE INFORMATION				
Insurance Company		Group#/Plan ID	Member Number	Copay Amount
				Effective Date
Subscriber Employer Name & Address		Patient Relationship to Insured:	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name & Address		Does your insurance require a referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to CHWCD to render needed treatment and/or tests to the above named patient.
2. I authorize CHWCD to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay noncovered and unauthorized service.
4. I understand that **I am responsible** for charges incurred through CHWCD, not covered by my insurance. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given CHWCD's handout on missed appointments and understand my responsibilities regarding being late or absent.