Washington Regional

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: _____-_____-_____ MRN#:_____

Name: _____ Home Phone: _____

Work Phone: _____Ext:_____

Address: _____ Cell Phone: _____

City: _____ Date of Birth: _____-____-_____ Age: _____yrs

State: _____ Zip Code: _____ Employer: _____

SEX: □ Male □ Female

Work Address: _____ Occupation: _____

City: _____ State: ____ Zip: _____

MARITAL STATUS: □ Married □ Single □ Divorced □ Partner □ Widowed □ Separated

Email:_____@_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

□ Washington Regional Medical Center □ Community or Company Health Fair □ Referred by a Physician: _____

□ Newspaper or Magazine □ Treated by Physician in hospital □ Employer

□ Recommended by friend or family member □ Internet □ Insurance Plan Directory

□ Drove by Location of Clinic □ Phone Directory (Yellow pages) □Return Patient/ Not Applicable □ Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ Cell: _____

Employer: _____ Work: _____ Ext: _____

Work Address: _____ Spouse/Parent SEX: □ Male □ Female

City: _____ State: _____ Zip: _____ Spouse/Parent Date of Birth: _____/_____/_____

Occupation: _____ Social Sec. #: _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ Cell Phone: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Washington Regional

PRIMARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ **Myself** ☐ **Spouse** ☐ **Child** ☐ **OTHER:** _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

ID# _____ **Group #** _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth:** _____/_____/_____

Main Holder's Address: _____ **Main Holder's Soc Sec#:** _____-_____-_____

City: _____

State: _____ **Zip:** _____

SECONDARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ **Myself** ☐ **Spouse** ☐ **Child** ☐ **OTHER:** _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

ID# _____ **Group #** _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth:** _____/_____/_____

Main Holder's Address: _____ **Main Holder's Soc Sec#:** _____-_____-_____

City: _____

State: _____ **Zip:** _____

Washington Regional

GENERAL INFORMATION

Who is responsible for Payment?: □ Myself □ Other:_____ (FILL OUT BELOW)

Responsible Party Name: _____ Responsible Party DOB: _____/_____/_____

Relationship to Patient: □Self □Spouse □Child □OTHER SS#_____-_____-_____

Address: _____ Phone#:_____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? □ Yes No_

If Yes, When?:_____/_____/_____ Where?:_____

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Preferred Language: □English □Spanish □Marshallese □Arabic □DECLINE OTHER: _____

Race: □ White □African American □ Asian □ Native Hawaiian/Other Pacific Islander □ Native American Indian/ Alaskan □Hispanic □Unknown □ DECLINE

Ethnicity (Origin): □ Not Hispanic or Latino □ Hispanic or Latino □Unknown □DECLINE

Preferred Communication Method: □Print □Save to Flash Drive □DECLINE

Wellness Reminders: □Mail □Cell Phone □Home phone □Work Phone □DECLINE

PREFERRED PHARMACY: _____ LOCATION: _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ Date: _____/_____/_____

Signature (Patient or Parent/Guardian if minor)