



## Patient Registration Form

Name \_\_\_\_\_ Emergency Contact (closest relative not living with patient) \_\_\_\_\_  
 Address \_\_\_\_\_ Contact's Phone # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Sex  M  F **(First, last name of physician and specify M.D. or D.O. please)**  
 DOB \_\_\_\_\_ Referring Physician \_\_\_\_\_  
 SSN \_\_\_\_\_ Other involved M.D.'s \_\_\_\_\_  
 Home # \_\_\_\_\_ Family Doctor \_\_\_\_\_  
 Cell # \_\_\_\_\_ Today's appt with \_\_\_\_\_  
 Alt # \_\_\_\_\_ Pharmacy Name \_\_\_\_\_  
 E-mail \_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_  
 How did you hear about our office?  TV  Radio  Newspaper  Magazine  Friend  
 Marital Status  Single  Married  Separated  Divorced  Widowed

### Primary Insurance

Company \_\_\_\_\_ Policy Holder \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_ SSN \_\_\_\_\_  
 Employer \_\_\_\_\_ DOB \_\_\_\_\_  
 Relation of patient to insured \_\_\_\_\_  **Same as patient information listed above.**

### Secondary Insurance

Company \_\_\_\_\_ Policy Holder \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_ SSN \_\_\_\_\_  
 Employer \_\_\_\_\_ DOB \_\_\_\_\_  
 Relation of patient to insured \_\_\_\_\_  **Same as patient information listed above.**

### Responsible Party Amounts not paid by insurance company will be billed to this person.

Name \_\_\_\_\_ Employer \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 City, State, Zip Code \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Phone # \_\_\_\_\_ Ext. \_\_\_\_\_  
 **Same as patient information listed above.**

### Comments and/or any special needs (i.e. wheelchair, stretcher, interpreter, etc.):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Consent to treat and authorization for release of billing information

Please read completely and sign. Services may be withheld if not signed.  
 I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from Wright State Physicians for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees of services rendered.

I have read the above and understand my financial responsibilities.

\_\_\_\_\_  
 SIGNATURE OF PATIENT (Parent or Guardian if a Minor)

\_\_\_\_\_  
 Date Signed