PATIENT REGISTRATION FORM

Patient Information

Name:____ **DOB:**_____/_____/_____
First Middle Last

Sex (circle one): Female Male **SSN:**____________________

Home Address:____

City:___________________________ **State:** _____ **Zip Code:**__________

Home Phone: ( ) ______________ **Cell Phone:** ( ) ______________ **Work Phone:** ( ) ______________

Preferred method of contact: __________________ **Language:**____________________

Ethnicity (circle one): Hispanic or Latino • Not Hispanic or Latino • Prefer not to answer

Race (circle one): American Indian or Alaska Native • Asian • Black or African American
Native or Other Pacific Islander • White • Other:____________ **• Prefer not to answer**

Marital Status (circle one): Single Married Divorced Other:__________

Preferred Pharmacy: ____ **Phone:** (___)________________

Preferred Lab: ____ **Phone:** (___)________________

Preferred Imaging Facility:____

How did you hear about Wright State Physicians?____

Primary Care Provider:_________________________ **Referring Provider:**__________________________

Other Providers:____

Insurance Information

Primary Insurance:____

Relationship of Patient to Insured (circle one): Self Spouse Child Other:___________________________

Name of Policy Holder:____

Address:__________________________________ **Birthdate:** _____/_____/_____ **M [ ] F [ ]**

City:_______________**State:**__________ **Policy #**_______________________ **Group#**__________

Secondary Insurance Carrier Name:____

Relationship of Patient to Insured (circle one): Self Spouse Child Other:___________________________

Name of Policy Holder: ____

Address:__________________________________ **Birthdate:**_____/_____/_____ **M [ ] F [ ]**

City:_______________**State:**__________ **Policy#**_______________________ **Group#**__________

CONSENT TO TREAT & 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 providers. I hereby authorize the release of any medical information necessary from Wright State Physicians for insurance claim submission and/or payment for services. I authorize payment of medical benefits to WSP for services described herein. Regardless of insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered. The adult presenting the child for treatment is responsible for payment at the time of service as well as any outstanding balances. We do not forward bills to other parties regardless of court rulings or divorce decrees.

Patient or Parent/Legal Guardian Signature:______________________________**Date:**_______________

Parent/Legal Guardian Name, if applicable (Printed)______________________________