

## PATIENT REGISTRATION

Today's Date \_\_\_\_\_ Home Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male or  Female Status:  S  M  D  W  
 Home Address \_\_\_\_\_ Apartment Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email address: \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Work Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
 Emergency Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Referred By \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 How did you hear about us?  Advertisement  Employer  Friend/Relative  Other: \_\_\_\_\_

**PRIMARY INSURANCE** Subscriber to Insurance:  Self  Spouse  Parent  Company  
 Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Insurance Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Address \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**SECONDARY INSURANCE** Subscriber to Insurance:  Self  Spouse  Parent  Company  
 Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Insurance Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Address \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**WORKERS COMPENSATION** Did you report the injury to your Employer?  Yes  No  
 Date of Injury \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM Claim Number \_\_\_\_\_  
 Where Injury Occurred \_\_\_\_\_  
 Employer Contact \_\_\_\_\_ Contact Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Claims Adjuster \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Insurance \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying Washington Township Medical Foundation of any changes made to my contact information and/or insurance.

**Medication History Consent:** I hereby authorize Washington Township Medical Foundation (WTMF) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice. I authorize WTMF to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY