



**Patient Registration**

**Patient Information:**

Reason for visit \_\_\_\_\_

Please give date of accident or symptom: \_\_\_\_\_

If injury, is it related to: Worker's Comp? Yes / No Motor Vehicle? Yes / No

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #'s: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Marital Status (circle one) S M D W O E-mail address \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male/Female

Is it okay to leave messages at: Home? Yes / No Work? Yes / No Cell? Yes / No

Retail (1) Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Retail (2) Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Patient's Primary Language: \_\_\_\_\_ Patient's Country of Origin: \_\_\_\_\_

Translator services required? Yes/No

Ethnicity \_\_\_\_\_ Race \_\_\_\_\_

Are you legally blind? Yes / No Are you hearing impaired? Yes / No

Primary Care Physician name: First \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Circle: Male / Female

Patient's Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Employment Status (circle one): Full-time / Part-time / Self-Employed / Retired / Military / Other

If student, indicate school \_\_\_\_\_ Student Status: Full-time / Part-time

**Emergency Contact Information (adult patient) or Parent/Guardian Information (minor patient):**

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Phone #'s: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION:**

**PRIMARY Insurance Company** \_\_\_\_\_

**If Medicare:**

Are you currently employed? Yes / No                      Is your spouse currently employed? Yes / No  
Is the patient a Veteran? Yes / No                      Do you have a Federal Black Lung Card? Yes / No

Policy / Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_  
How is the subscriber related to you?                      Self / Spouse / Child / Guardian

Preferred Lab Company:                      ACL (AtlantiCare) / Labcorp / Quest

**Policyholder / Subscriber Information:**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male / Female  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone #'s: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
E-mail address \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

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**SECONDARY Insurance Company** \_\_\_\_\_

Policy / Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

How is the subscriber related to you?                      Self / Spouse / Child / Guardian

**Policyholder / Subscriber Information:**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male / Female  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone #'s: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
E-mail address \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_