

WAYNE MEMORIAL COMMUNITY HEALTH CARE CENTERS

PATIENT REGISTRATION FORM DATE _____

FIRST NAME: _____ LAST NAME _____ DATE OF BIRTH _____

ADDRESS: _____ HOME PHONE: _____
CELL PHONE: _____

EMAIL: _____ ALTERNATE PHONE: _____

CONTACT BY: Circle One- Phone Email SEX: M F SOCIAL SECURITY # _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ TELEPHONE # _____

FAMILY (PRIMARY CARE) PHYSICIAN: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

IF MINOR CHILD - NAME OF PARENT OR GUARDIAN: _____

* GUARANTOR IS THE PERSON FINANCIALLY RESPONSIBLE FOR BALANCES. IF OTHER THAN THE PATIENT PLEASE
PROVIDE REQUIRED INFORMATION GUARANTOR IS: PATIENT OTHER

ADDRESS: _____

SOCIAL SECURITY # _____ TELEPHONE # OF GUARANTOR: _____

INSURANCE INFORMATION-PLEASE PROVIDE CARD
PATIENT WILL BE CONSIDERED A SELF-PAY ACCOUNT UNTIL INFORMATION IS PROVIDED

PRIMARY INSURANCE: _____

INSURANCE ADDRESS _____

PRIMARY INSURANCE HOLDER INFORMATION: INSURED IS: PATIENT OTHER

INSURANCE ID# _____

GROUP ID# _____

NAME OF INSURED (POLICY HOLDER): _____

POLICYHOLDER DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT _____

ADDRESS OF INSURED: _____

TELEPHONE NUMBER OF INSURED: _____

SOCIAL SECURITY NUMBER OF INSURED: _____

SECONDARY INSURANCE: _____

INSURANCE ADDRESS _____

SECONDARY INSURANCE HOLDER INFORMATION: INSURED IS: PATIENT OTHER

INSURANCE ID# _____

GROUP ID# _____

NAME OF INSURED (POLICY HOLDER): _____

POLICYHOLDER DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT _____

ADDRESS OF INSURED: _____

TELEPHONE NUMBER OF INSURED: _____

SOCIAL SECURITY NUMBER OF INSURED: _____

PHARMACY PREFERENCE _____

I undersigned, hereby grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Signature: _____ Date: _____

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.