Well Being Health Care

PATIENT REGISTRATION INFORMATION

First Name:_____ M.I. _____ Last Name:_____ Preferred Name:_____

Preferred Language: _____ Birth Date: _____ Age: _____ Soc. Sec. #: _____

Street Address: _____ Apt: _____ City: _____ State: _____

Zip Code: _____ Home Tele: (___)_____ Cell Tele: ( )_____

Referred by: _____ Has a family member ever been a patient of our practice? ◦ Yes ◦ No

Primary Dr. _____ Preferred Pharmacy: _____ Tel: (___)_____

Preferred Imaging Center: _____ Tele: _____

Employment Status: ◦ Full time ◦ Part time ◦ Unemployed ◦ Student

Marital Status: ◦ Single ◦Married ◦ Divorced ◦ Widow ◦ Widower ◦Legally Separated

Spouse Name: _____ Domestic Partner name: _____

In case of emergency, please contact: _____ Tele: (___) _____

Relationship to patient: _____

Can our office leave a voicemail or text message regarding appointments? ◦ Yes ◦ No

PRIMARY MEDICAL INSURANCE COMPANY

Insurance Company: _____
ID# _____ Group# _____
Effective Date: _____

SUBSCRIBER INFORMATION

Subscriber Name: _____
Date of Birth: _____ ☐ Spouse ☐ Parent ☐ Other
Address: _____ City: _____
State: _____ Zip: _____
Employer: _____

SECONDARY MEDICAL INSURANCE COMPANY

Insurance Company: _____
ID# _____ Group# _____
Effective Date: _____

SUBSCRIBER INFORMATION

Subscriber Name: _____
Date of Birth: _____ ☐ Spouse ☐ Parent ☐ Other
Address: _____ City: _____
State: _____ Zip: _____
Employer: _____

MRN# _____