

PATIENT REGISTRATION

Welcome to Wintergreen Medical Center. We are committed to providing the best service and most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent as per our privacy policy.

| DEMOGRAPHIC INFORMATION | | | | |
|---|-----------------|---|--------------------------|------------|
| Patient Name | Today's Date | Date of Birth | Sex | Age |
| Parent Name if Patient is a Minor | | | | |
| Patient Social Security Number | | Driver's License Number | | |
| Mailing Address | City | State | Zip | |
| Please circle the preferred method of contact: | | Home Phone | Work Phone | Cell Phone |
| Email Address | | | | |
| Occupation | Employer's Name | | | |
| Employer's Address | City | State | Zip | |
| Other Physicians' Name(s) | | | | |
| NOTIFY IN CASE OF EMERGENCY | | | | |
| Name | | Relation | | |
| Address | City | State | Zip | |
| Home Phone | Work Phone | Cell Phone | | |
| PHARMACY INFORMATION | | | | |
| Preferred Pharmacy (may list 1 or 2) | | Location (be specific-ex: there are 2 Walgreens on Firetower) | | |
| Pharmacy Phone | | | | |
| INSURANCE INFORMATION | | | | |
| Insurance Carrier | | Primary Care Provider Co-pay | | |
| Insured's Name (name of spouse or parent who carries the insurance policy) | | Insured's DOB | Insured's Address | |