

# PATIENT REGISTRATION

## Wintergreen Medical Center

Welcome to our office. We are committed to providing the best, 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's Social Security Number                           |                            | NC Driver's License No. |                                  |     |    |
| Home Address   | City                       | State                   | Zip                              |     |    |
| Mailing Address (if different)                             | City                       | State                   | Zip                              |     |    |
| Please circle preferred means of contact:<br>Email address | Home Phone                 | Work Phone              | Cell Phone                       |     |    |
| Occupation   | Employer's Name            |                         |                                  |     |    |
| Employer's Address   | Street                     | City                    | State                            | Zip |    |
| Spouse Name  | Employer                   |                         |                                  |     |    |
| Other Physicians' Name(s)                                  |                            |                         |                                  |     |    |
| Whom May We Thank for Referring You to Our Practice?       |                            |                         |                                  |     |    |
| NOTIFY IN CASE OF EMERGENCY                                |                            |                         |                                  |     |    |
| Name   | Relationship               |                         |                                  |     |    |
| Address  | City                       | State                   | Zip                              |     |    |
| Home Phone   | Work Phone                 | Cell Phone              | Email                            |     |    |
| Nearest Relative (not living with you)                     |                            |                         |                                  |     |    |
| Home Telephone   | Work Telephone             |                         |                                  |     |    |
| FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES         |                            |                         |                                  |     |    |
| Name   | Telephone                  |                         |                                  |     |    |
| Address  | City                       | State                   | Zip                              |     |    |
| Insurance Company  | Claim Address              |                         |                                  |     |    |
| Subscriber's Name  | Subscriber's Date of Birth | Subscriber's SSN#.      |                                  |     |    |
| Insurance ID No.:  | Group No.:                 |                         |                                  |     |    |
| Secondary Insurance  | Claim Address              |                         |                                  |     |    |
| Subscriber's Name  | Subscriber's Date of Birth | Subscriber's SSN#       |                                  |     |    |
| Insurance ID No.:  | Group No.:                 |                         |                                  |     |    |
| Were You Injured on the Job?                               | YES                        | NO                      | Have you Informed Your Employer? | YES | NO |
| Date of Original Injury:                                   |                            |                         |                                  |     |    |
| Worker's Compensation Carrier Name                         | Address                    |                         |                                  |     |    |