

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Dr Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) (First) (MI) Previous Name

Address Line 1

City, State ZIP

Home Phone Cell No. Work Phone Ext.

Primary Care Provider (PCP) Referring Provider

Rendering Provider Name (this practice) E-Mail Address:

Date of Birth MM/DD/YYYY Sex F - Female M - Male Transgender

Race American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number Employer Name

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N - Not a Student

Emergency Contact Last Name First Name

Phone Number Do you have a living will? Yes No

Emergency Contact Relationship to Patient Guardian

Address Line 1

City, State ZIP

Home Phone Work Phone Ext.

Referring Provider Name

(information used for patient balance statements)

RESPONSIBLE PARTY INFORMATION

Responsible Party Another Patient Guarantor Self Check here if information is same as patient

Responsible Party Name (Last) (First) (MI)

Guarantor Account Number Date of Birth MM/DD/YYYY

Social Security Number Telephone

E-Mail Address Sex F - Female M - Male

Address Line 1

City, State ZIP

Employer Employer Phone Number

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date

LewisGale Physicians  
Patient Registration Form

Office Use Only  
MRN# \_\_\_\_\_

PATIENT INFORMATION (Please Print)

Dr.  Mr.  Mrs.  Ms.  Jr.  Sr.  Other \_\_\_\_\_  
Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Also Known As Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Other  
Social Security Number \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
E-Mail Address \_\_\_\_\_

Send communications, announcements and updates via email.  Yes  No

Phone Numbers Work \_\_\_\_\_  Day  Evening Home \_\_\_\_\_  Day  Evening  
Cellular \_\_\_\_\_ Pager \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact Relationship to Patient \_\_\_\_\_

Referring Provider Name \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION (Please Print)

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Also Known As Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Social Security Number \_\_\_\_\_  Female  Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail Address \_\_\_\_\_

Phone Numbers Work \_\_\_\_\_  Day  Evening Home \_\_\_\_\_  Day  Evening

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

Patient Relationship to Responsible Party \_\_\_\_\_

PRIMARY INSURANCE INFORMATION (Please Print) (provide your insurance card to the front desk at check-in)

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Insured Employer Name \_\_\_\_\_

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male

Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

SECONDARY INSURANCE INFORMATION (Please Print) (provide your insurance card to the front desk at check-in)

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Insured Employer Name \_\_\_\_\_

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male

Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

# LewisGale Physicians

## Patient Registration Form

<b>Office Use Only</b> MRN# _____
--------------------------------------

**PATIENT INFORMATION** (Please Print)

---

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**TERTIARY INSURANCE INFORMATION** (Please Print) (provide your insurance card to the front desk at check-in)

---

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_  
 Insured Employer Name \_\_\_\_\_  
 Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_  
 Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male  
 Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Insurance Company Address \_\_\_\_\_

---

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

**Patient (or Responsible Party) Signature** \_\_\_\_\_ **Date** \_\_\_\_\_