



# WEISS PHYSICIANS PATIENT REGISTRATION FORM

**Physician:****Office:**

(Please Print)  
 Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Title \_\_\_\_\_  
 Legal Guardian (if a minor) \_\_\_\_\_ Relationship \_\_\_\_\_  
 Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  Male  Female Cell # (\_\_\_\_) \_\_\_\_\_  
**Social Security #** \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status  S  M  W  D Race \_\_\_\_\_  
 Referred By \_\_\_\_\_  
 Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Street City State Zip (Area code) Telephone

**GUARANTOR/RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)**

Guarantor Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Last First MI  
 Address \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Street City State Zip (Area code) Telephone  
**Social Security #** \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  M  F  
 Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Street City State Zip (Area code) Telephone

**PRIMARY INSURANCE**

Name of Insurance Co \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Address \_\_\_\_\_ Ins Telephone # (\_\_\_\_) \_\_\_\_\_  
 Insurance ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Employer Name/Address \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance Co \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Address \_\_\_\_\_ Ins Telephone # (\_\_\_\_) \_\_\_\_\_  
 Insurance ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Employer Name/Address \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact person \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Alternate Phone # (\_\_\_\_) \_\_\_\_\_

**ADVANCE DIRECTIVE/LIVING WILL**

Do you have an Advance Directive? (Living Will/Power of Attorney)  Yes  No **If yes, provide a copy for our records**  
 Advance Directive information provided \_\_\_\_\_ (office staff initials)  
 Patient Rights and Responsibility information provided \_\_\_\_\_ (office staff initials)

**ASSIGNMENT OF INSURANCE BENEFITS, CONSENT FOR TREATMENT, AND AUTHORIZATION TO  
RELEASE INFORMATION**

I hereby authorize the physician at Weiss Memorial Hospital, the nurses, and staff, under their direction, to conduct such examinations, administer treatment and medications, as they deem necessary or advisable. I verify the accuracy of the above information and I authorize the release of pertinent medical information necessary to my insurance company to process medical claims. I authorize insurance payment to be made directly to designated Provider. I understand that my insurance may not cover particular services and am aware that I am fully responsible for all charges. Payment is requested at time of service if provider is not contracted with my insurance plan.

Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**For Office Use Only (New Patients/Ins Changes)**

Appt Date \_\_\_\_\_ PCP \_\_\_\_\_

Copay \$ \_\_\_\_\_ Deductible \_\_\_\_\_

Info by \_\_\_\_\_ Verified \_\_\_\_\_