PRINT

Westover Hills Primary Care

Patient Registration

DATE: 03/18/2019

PATIENT INFORMATION		
Last, First, MI:		
Date of Birth:		○Male ○Female
SSN:		Marital Status: ○S ○M ○W ○D ○SEP
Address:		City/State/Zip:
Home Phone:	Work Phone:	Cell Phone:
Employer:		Occupation:
Employer address:		City/State/Zip:
Email Address:		Race: ○White ○Hispanic ○Black ○Asian
Primary Care Physician:		Ethnicity: ○Hispanic ○Not Hispanic
Preferred Language:		
Preferred Way To Communicate: ○E -mail ○Cell Phone ○Home Phone ○Work Phone		
How were you referred to our office? ○Phone Book ○Friend ○Insurance ○Employer ○Other		
PRIMARY INSURANCE		
Primary Insurance Company:		Subscriber ID#:
Last, First, MI:		Group #:
Date of Birth:		○Male ○Female
SSN:		
Address:		City/State/Zip:
Home Phone:	Work Phone:	Cell Phone:
Employer:		Occupation:
Relationship to Patient:		Email Address:
SECONDARY INSURANCE		
Insurance Company:		Subscriber ID#:
Last, First, MI:		Group #:
Date of Birth:		○Male ○Female
SSN:		
Address:		City/State/Zip:
Home Phone:	Work Phone:	Cell Phone:
Employer:		Occupation:
Relationship to Patient:		Email Address:
EMERGENCY CONTACT PERSON		
Last, First, MI:		Email address:
Address:		City/State/Zip:
Home Phone:		Cell Phone

Advanced Directive? ☐

if yes: ○Do not resuscitate.
○Spouse / child to make decision

Impaired Vision? ☐
Hard of Hearing? ☐

Office use only:

☐ HIPAA