PATIENT REGISTRATION

Last Name________________________________ **First Name** _____________________________ **MI** _________

Address____**Telephone Number** _______________________

City ____________________________________ **State** _______ **Zip Code** _________________________________

Social Security Number _______-________-_______ **Date of Birth** _____/______/______ **Sex: Male Female**

Patient Status (CIRCLE ONE) **Single Married Divorced Widow Separated**

Spouse's Name __________________________________ **Work Phone Number** _____________________
(if under 18) Fathers Name ________________________ **Work Phone Number** ____________________
Mothers Name ______________________ **Work Phone Number** _____________________

Are You: _____**Employed** _____ **Retired** _____ **Student** _____ **Unemployed**

Employer/School Name ______________________________________**Telephone Number**___________________

Address_______________________________________ **City** ____

State ___________ **Zip Code** _________________________ **Occupation** __________________________________

EMERGENCY CONTACT PERSON____
Telephone Number _________________________________Relationship _________________________________

PRIMARY INSURANCE ____

ID # ____GROUP # ____________________________________

Subscribers Name _________________________________Birthdate ______/_________/________

Subscribers Address _______________________________City ____

State ________ Zip Code ________________ Social Security Number _________-___________-______________

Telephone Number _______________________Employers Name _______________________________________

Relationship of patient to Insured: _____ Self _____ Spouse _____ Child _____ Other

SECONDARY INSURANCE ____
ID # ____ GROUP # _________________________________
Subscribers Name __________________________________ Birthdate ______/_______/________
Subscribers Address ________________________________ City ____
State ________ Zip Code _______________ Social Security Number _____________________________________
Telephone Number ______________________ Employers Name ____
Relationship of patient to Insured: _____ Self _____ Spouse _____ Child _____ Other

AUTO OR WORKMENS COMPENSATION INFORMATION

WORK RELATED _____ **AUTO RELATED** _____ **DATE OF INJURY** _______/________/________
Insurance company ____
Address ____ City _______________________________________
State __________ Zip Code _______________ Telephone Number ______________________________________
Adjusters Name _______________________________ Claim # ____

FAMILY / PRIMARY CARE PHYSICIANS NAME ____
ADDRESS ____ **Telephone Number** ____________________

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plan to Pottstown Medical Specialists, Inc.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by such insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient or Authorized Person __________________________________**Date** ____/_____/_____