

Patient Registration Form (eCW)
Primary Health Group - Appomattox

PATIENT INFORMATION

(Please Print)

Dr. Miss Mr. Mrs. Ms. Sir

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

Address Line 1 _____

City, State _____ Zip _____ Pharmacy _____ Pharmacy Phone _____

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 _____

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

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** _____