

Practice Name:

Wade Dickinson, M.D.



PATIENT REGISTRATION FORM (Please print)

Patient Demographics section with fields for First Name, Last Name, Date of Birth, Home Address, City, State, Zip, Home Phone, Cell Phone, Email, Emergency Contact Name & Relation, SSN, Age, Sex, Marital Status, Employer, Occupation, Work Address, Work Phone, and Emergency Phone (diff. than home).

Responsible Party Info (if other than patient) section with fields for First Name, Last Name, Date of Birth, Home Address, City, State, Zip, Home Phone, Cell Phone, Relation to Patient, SSN, Age, Sex, Employer, Occupation, Work Address, and Work Phone.

Insurance Information section with fields for Primary Insurance Name, Subscriber Name, Insurance Address, Subscriber DOB, Ins. Card Provided, Subscriber ID, Group ID, PCP Assigned, and Secondary Insurance Name, Subscriber Name, Insurance Address, Subscriber DOB, Ins. Card Provided, Subscriber ID, Group ID, PCP Assigned.

Consent for Treatment section with a paragraph of consent text for medical or surgical treatment and release of medical information.

Financial Respons. section with a paragraph of authorization text for payment and release of financial and medical information.

Notice of Privacy Practice section with a paragraph of acknowledgment text regarding the privacy policy.

Contact information section with a table for preferred method of contact (Health Fair, Friend or Family, Insurance Assignment, Online Search, Referral, Post Mail) and a field for how they heard about the office.

Patient/Responsible Party Signature

Date