Patient Registration Form (eCW)

PATIENT INFORMATION	
□Dr. □Miss □Mr. □Mrs. □Ms. □Sir	
Patient's Name (Last)(First)	(MI) Previous Name
Address, City, State, ZIP	
Home Phone Cell No	Work Phone Ext
Primary Care Provider (PCP)	Referring Provider
Rendering Provider Name (this practice)	Date of Birth MM/DD/YYYY
E-Mail Address	Permission to Contact via Email Yes No
Race American Indian/Alaska Native Asian Native Hawaiian/Pacific Islam	nder Black/African American White Hispanic Other Declined
Ethnicity Hispanic or Latino Not Hispanic or Latino Declined	Sex F-Female M-Male Transgender
Language English Spanish Indian Japanese Chinese Ko	rean 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 Employ	yed 4 – Self-Employed 5 – Retired 6 – Active Military
Student Status F – Full-Time Student P – Part-Time Student	N – Not a Student
Emergency Contact Name_	Phone Number
Emergency Contact Relationship to Patient	Guardian
Address Line 1	
City, State, ZIP	
Home Phone Work Phone	
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)	_
Guarantor Account Number Date of Bi	
Social Security Number Telephone	
E-Mail Address	
Address, 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	
Subscriber ID (Policy Number) Group ID	
Effective DateTermination Date	
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 DateTermination Date	Date of Birth MM/DD/YYYY
HOW DID YOU LEARN ABOUT US?	(check all that apply)
Referring Provider Google + Other Social Media	a Other
Family/Friends Online Profile Other Physician Pro Website Facebook Living Well Magazin	ofile
Search Engine D Magazine HealthGrades or Vi	
I agree that the information supplied on this form is accurate and up-to-date to the	e best of my knowledge.
Patient (or Responsible Party) Signature	Date Date

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