BRENTWOOD EAST FAMILY MEDICINE

Patient Registration Form (eCW)

PATIENT INFORMATION

☐ 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. _____

E-Mail Address:_____Social Security Number _____-_____-_____

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

Employer Name _____Work Phone _____Ext. _____

Emergency Contact Name _____Phone Number _____

Emergency Contact Relationship to Patient _____

Do you have a living will? ☐ Yes ☐ No

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 _____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***_____