DEPARTMENT OF INTERNAL MEDICINE

PATIENT PRE- REGISTRATION INFORMATION
SELF REFERRAL

FOR DOCTOR: **PATIENT NUMBER:**

PATIENT NAME: _____
Last **First** **Middle**

ADDRESS:_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE NUMBER: (____)_____ **WORK/CELL#:** _____ **DOB:** _____

SSN: _____ **GENDER:** _____

REASON FOR VISIT: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE # :(____)** _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ **PHONE# :(____)** _____

INSURANCE: SEND COPY OF INSURANCE CARD(S) FRONT AN BACK IF POSSIBLE: SELF PAY_____ **INDIGENT**_____

PRIMARY COMPANY NAME: _____

POLICY ID #:_____ **POLICY GROUP #:**_____

MAILING ADDRESS:_____

PHONE #: (____)_____ **SUBSCRIBER NAME:**_____

SUBSCRIBER DOB: _____**RELATIONSHIP TO PATIENT:** _____ **EFFECTIVE DATE:** _____

SECONDARY COMPANY NAME: _____

POLICY ID #:_____ **POLICY GROUP #:**_____

MAILING ADDRESS:_____

PHONE# (____)_____ **SUBSCRIBER NAME:**_____

SUBSCRIBER DOB: _____**RELATIONSHIP TO PATIENT**_____**EFFECTIVE DATE:** _____

EMPLOYER: _____**PHONE #:** _____

EMPLOYER ADDRESS: _____

COPAY FIRST INS: _____**COPAY SECOND INS:** _____

*****PLEASE BRING YOUR INSURANCE CARD(S), DRIVERS LICENSE, AND/ OR A PHOTO ID*****

OFFICE USE ONLY

APPOINTMENT DATE AND TIME: _____

INFO TAKEN/ENTERED INTO TIGER BY: _____ **DATE NP PACKET MAILED:** _____

PLEASE NOTE

IF YOU ARE UNABLE TO MAKE PAYMENT IN FULL AT THE TIME OF SERVICES ARE RENDERED, YOU MAY REQUEST TO SEE OUR FINANCIAL COUNSELOR. WE REQUIRE THAT YOU BRING YOUR MOST RECENT BANK STATEMENT, LAST YEAR'S TAX RETURN, AND YOUR LAST TWO PAY STUBS.