PATIENT REGISTRATION

WeCare Medical Associates

Referring Physician: _____

Primary Physician: _____ Telephone: _____

Pharmacy: _____ Telephone: _____

PATIENT INFORMATION

Patient First Name:	M.I:	Last Name:	Date of Birth / /
Social Security Number:	Age:	Gender (Circle): Male Female	Race (Circle): Caucasian Hispanic Asian African American Native American Other (Specify):
Mailing Address:	City:	State:	Zip Code:
Residential Address (if different from mailing):	City:	State:	Zip Code:
Home Phone #: ( )	Work Phone #: ( )	Marital Status (Circle): Single Married Other Divorced Widowed Separated	

EMERGENCY CONTACT INFORMATION

Name:	Home Phone #	Relationship to Patient:
	Work Phone#	
	Cell Phone #	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Patient First Name:	M.I:	Last Name:	Date of Birth / /
Social Security Number:	Age:	Relationship to Patient:	
Address:	City:	State:	Zip Code:
Home Phone #: ( )	Work Phone #: ( )	Cell Phone #: ( )	

1° PRIMARY INSURANCE FOR PATIENT	2° SECONDARY INSURANCE FOR PATIENT
Insurance Name:	Insurance Name:
Insurance Phone #:	Insurance Phone #:
Insurance Address:	Insurance Address:
Policy or ID # :	Policy or ID # :
Group #: (if applicable)	Group #: (if applicable)
Date Insurance Effective:	Date Insurance Effective:
Policy Holder Information:	**Policy Holder Information:**
Policy Holders Name:	Policy Holders Name:
Relationship to actual Patient:	Relationship to actual Patient:
Date of Birth:	Date of Birth:
Social Security #	Social Security #
Employer:	Employer:
Employer Phone #:	Employer Phone #:

Please let us know if you require assistance in completing this form. We'd be glad to help.