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Westside Primary Care Associates

Patient Registration Form

Patient's Name (Last, First, MI):_____

Patient's Home Phone Number:_____ Alt. Phone Number (☐ cell or ☐ work):_____

Email Address:_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ Sex: M F Social Security Number:_____

Marital Status: [ ] Married [ ] Single [ ] Divorces [ ] Widowed

Patient's Employer:

_____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [ ] Student [ ] Other:_____

Emergency Contact:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

INSURANCE INFORMATION

Primary Insurance:_____

Patient is Subscriber Policy Holder: Y N

Secondary Insurance:_____

Patient is Subscriber Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) – We will request to scan your ID and insurance card

Subscriber Policy Holder:_____ Relationship to Patient:_____

Address:_____

Social Security Number:_____

Date of Birth: _____

His or Her Employer:_____ Work Phone Number:_____

AUTHORIZED TO LEAVE VOICE MAIL? YES___ NO___

The above information is true to the best of my knowledge:

Patient/Guardian Signature:_____ Date:_____