Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

PATIENT REGISTRATION

Today's Date:_____ Home Phone #_____-_____-_____ Cell Phone #_____-_____-_____

Patient's Last Name:_____ First:_____ Middle Initial:_____

SS #_____-_____-_____ Date of Birth_____/_____/_____ ❑Male or ❑Female *Status*: ❑S ❑M ❑D ❑W

Home Address:_____ Apartment Number:_____

City:_____ State:_____ Zip Code:_____ Email address:_____

Occupation:_____ Employer Name:_____

Employer Address:_____ City:_____ State:_____ Zip Code:_____

Work Phone #_____-_____-_____ Emergency Contact:_____

Emergency Phone #_____-_____-_____ Relationship to Patient:_____

Referred By:_____ Primary Care Physician:_____

How did you hear about us? ❑Advertisement ❑Employer ❑Friend/Relative ❑Other:_____

Race: Please mark what best describes you. If more than one, please mark numerically in order.

☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Black/African American

☐ Asian:_____ ☐ Native Hawaiian/Other Pacific Islander

☐ Other:_____ ☐ Decline

Ethnicity: Do you consider yourself Hispanic/Latino? ❑ Yes ❑ No ❑ Decline

Which **Language** do you speak in your home?_____

PRIMARY INSURANCE: Subscriber to Insurance: ❑ Self ❑ Spouse ❑ Parent ❑ Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient:_____ SS #_____-_____-_____ Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

SECONDARY INSURANCE: Subscriber to Insurance: ❑ Self ❑ Spouse ❑ Parent ❑ Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient:_____ SS #_____-_____-_____ Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

WORKERS COMPENSATION: **Did you report the injury to your Employer? ❑ Yes ❑ No**

Date of Injury:_____/_____/_____ Time:_____ AM/PM Claim Number:_____

Where Injury Occurred:_____

Employer Contact:_____ Contact Phone #_____-_____-_____

Claims Adjuster:_____ Phone:_____-_____-_____ Fax:_____-_____-_____

Insurance:_____ Address:_____

City:_____ State:_____ Zip Code:_____

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying Washington Township Medical Foundation of any changes made to my contact information and/or insurance.

Medication History Consent: I hereby authorize Washington Township Medical Foundation (WTMF) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice. I authorize WTMF to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

_____ _____

DATE **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**