Date:_____

DOMINION INTERNAL MEDICINE

Patient Registration Form

Person Responsible for Bill: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#:_____ Work#:_____ Cell#:_____

Email Address: _____

Patient Information

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

Address:_____

City: _____ State: _____ Zip: _____

Home Phone# _____ Work Phone#_____ Cell Phone#_____

Male ☐ Female ☐ Marital Status S____ M ____ D ____W ____ Spouse Name: _____

Patient Social Security #:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Emergency Contact

Emergency Contact: _____ Relationship _____

Contact #: ( ) _____-_____

Preferred Method of Communication

Please Circle

Cell **Home** **Mail** **Work** **Other**: _____

How did you hear about us?_____

Insurance Information

Primary Insurance:_____ Policyholder:_____ Relationship:_____

Employer of Policyholder:_____

Member ID#: _____ Group#: _____

Policyholder SSN:_____ Policyholder DOB: _____

Secondary Insurance:_____ Policyholder:_____ Relationship:_____

Employer of Policyholder:_____

Member ID#: _____ Group#: _____

Policyholder SSN:_____ Policyholder DOB: _____

Workers' Compensation Information

WC Carrier Name: _____ Phone #: _____

Claim #: _____ Date of Injury: _____