NORTHWEST PHYSICIANS ASSOCIATES, P.C.
PATIENT REGISTRATION FORM

PATIENT INFORMATION *(Please write information about the patient here)*

First Name: _____ MI: _____ Last Name: _____ Sex: M ☐ F ☐

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Social Security#:_____

Date of Birth: _____/_____/_____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed

Driver's License #: _____ Race: ☐ Asian ☐ African American/Black ☐ Caucasian ☐ Hispanic ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Native Hawaiian ☐ More than one race ☐ Other Pacific Islander ☐ Other ☐ Decline to Report

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Filipino ☐ Decline to Report

Preferred Language: _____ (English, Spanish, French, etc.)

Preferred Contact Method: _____ (Postal mail, Phone, Secure messaging/Patient Portal)
*Note that this may be used for appointment reminders, test results, and other communications from the practice.

Patient Pharmacy & Address: _____

Preferred Lab: ☐ NPA ☐ ACL ☐ MMC ☐ UPMC ☐ Skin Path ☐ Other _____

Patient Email Address:_____ Primary Care Physician: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

INSURANCE INFORMATION *(Please write information about the patient's insurance here)*

PRIMARY Insurance Company: _____

If patient is **not** the policyholder please complete the following information regarding the policyholder.

Policy Holder's Name: _____ Date of Birth: _____/_____/_____ SS#: _____

Relationship to Patient: _____ Home Phone #: _____

SECONDARY Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____/_____/_____ SS#: _____

Relationship to Patient: _____ Home Phone #: _____

RESPONSIBLE PARTY INFORMATION (Please complete the information below if the person responsible for paying the bill is not the patient)

Responsible Party's First Name: _____ M: _____ Last Name: _____

Responsible Party's Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Relationship to Patient: _____Spouse _____Parent _____Guardian _____Other

Social Security #: _____ Driver's License #:_____

INJURY RELATED VISIT: (Please complete the information below ONLY if the reason for your visit is related to an injury/claim)

Type of Injury: ☐ Auto ☐ Work ☐ Other

Claim #: _____

Auto Related:
Auto Insurance Name: _____ Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Work Related:
Employer's Name: _____ Phone #: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

REFERRAL SOURCE:

☐ Friend/Relative ☐ Web Search (Google, Yahoo, etc) ☐ Online yellow pages ☐ Phone Book ☐ Insurance

☐ Doctor (name of doctor): _____ ☐ Other: _____

PLEASE READ AND SIGN ONE OF THE BELOW:
(IF YOU HAVE MEDICARE COVERAGE AND ANOTHER SECONDARY COVERAGE, PLEASE READ AND SIGN BOTH.)

MEDICARE PATIENTS:

(I) Direct Payment Request and Authorization to Release Medical Information

"I request that payment of authorized Medicare benefits be made either to me or on my behalf of Northwest Physicians Associates, P.C. for any services furnished to me by that physicians or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Beneficiary Signature: _____ Date: _____

ALL OTHER PATIENTS:
(I) Direct Payment Request and Authorization to Release Medical Information

"I request that payment of authorized benefits be made either to me or on my behalf to Northwest Physicians Associates, P.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient Signature: _____ Date: _____