

Please print clearly

I acknowledge WSPCA has provided or offered me with a copy of their Privacy Practices.

Signature

WESTSHORE PRIMARY CARE ASSOC. INC

Patient Registration

Staff Use: Copy of Driver's License [] Yes [] No DL #

Name [] Male [] Female DOB / / Age:

Address Apt# City St. Zip

Employer/School Occupation

SSN - - Martial status: [] single [] married (spouse name) [] divorced [] widowed

E-mail Address

Home Phone () (see below)

Work/Cell Phone () (see below)

[] Yes [] No Ok to leave message with detailed information

[] Yes [] No Ok to leave message with detailed information

[] Yes [] No Ok to leave message with (specify name)

[] Yes [] No Leave message with callback number only

[] Yes [] No Leave message with callback number only

Patient's Emergency Contact Phone ()

For minors only: Does the child live [] with both parents [] mother [] father [] (other)

Insurance Information

Policy Holders Name Employer

DOB / / SSN Relationship to Patient [] Self [] Spouse [] Mother [] Father [] Other

Policy Holders Address Employer Address

City St. Zip City St. Zip

Home Phone () Work/Alternate Phone ()

Primary Insurance

Secondary Insurance

Insurance Name Effective Date

Insurance Name Effective Date

Address Policy/Group

Address Policy/Group

Authorization: I, with my signature, authorize Westshore Primary Care Associates, Inc., and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize Westshore Primary Care Associates, Inc., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification or payment of health care services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed. I shall assign all payments for these services to Westshore Primary Care Associates. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my health care insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient/Guardian Date

I have reviewed the above information and there are no changes.

Reviewed Annually [] 09 [] 10 [] 11 [] 12 [] 13 [] 14 [] 15 [] 16 [] 17 [] 18 [] 19