COMMONWEALTH PRIMARY CARE

Physician/Location (select one): ☐ Glen Forest ☐ Huguenot ☐ Ridgefield ☐ RPC ☐ Three Chopt ☐ Wyndham

Patient Registration

In order to meet criteria established by the Federal Government through the Electronic Health Record (EHR) Incentive Program, our Physician Practice must obtain complete demographic data on every patient including preferred language, race, and ethnicity. If you prefer not to answer these questions you may choose to decline. Thank you for your cooperation.

Date_____________Name____
Last First Middle Suffix

Date of birth_______________________ Sex (M/F) ______ SSN#_______________________________________

Primary Language:__________________________ ☐ Declined

Race:
☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Declined
☐ Other:______________________

Ethnicity:
☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Declined

Marital Status__________________ Drivers License # ________________________ State____________________

Address____
City State Zip

Home Phone _____________________Work Phone________________________ Cell_______________________

Email ____

………

Pharmacy_________________________________ Phone #____

Pharmacy Address____

………

Employer___________________________________ Occupation____

Address____
City State Zip

………

Insurance Information: Do you request that we file your insurance and authorize your company to pay us benefits directly? ☐Yes ☐No

Carrier____Policy Holder______________________

Date of Birth________________ Relationship____________________ Social Security # _____________________

Policy # ________________ Group # __________________ Effective Date_______________________________

………

Emergency Contact________________________ Phone________________________Relationship______________

………

Referring Physician____

………

Patient's or authorized person's signature: I authorize the release of any medical information to any insurance company, Medigap Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to Commonwealth Primary Care, Inc. I understand that I am financially responsible for all charges, whether or not covered by insurance. Also, if my account has to be turned over to collections, I agree to pay all costs of collections including attorney fees.

____________________________________ ____________________________

Signature: Patient or Guardian Date