**RANDOLPH PRIMARY CARE REGISTRATION FORM**

(Office use only)

**Circle one – Caucasian / Hispanic / African American / other** Acct#\_\_\_\_\_\_\_\_\_\_\_

**Methods for communication: Phone\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Preferred Pharmacy Location/Address Phone Number**

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Patient’s Last Name First Name Middle/Maiden Name Date of Birth Sex

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Marital Status Social Security Number Driver’s License/State Home Phone Number Cell Phone Number

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Street Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Employer Address Employer Phone Number

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Spouse’s Name Spouse’s Date of Birth Spouse’s Employer Spouse’s Phone cell / work numbers

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 Previous Physician Address Phone Number

**Responsible Party and Emergency Information – (a copy of power of attorney or guardianship is required)**

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Person responsible for bills Relationship Address Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Contact In Case Of Emergency Relationship Phone Number

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Legal Guardian / Healthcare POA Address Phone Number Hospice Agency Phone Number

**Insurance Information – (copies of ALL insurance cards are required)**

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Primary Insurance Policy Holder’s Name Policy Holder’s Social Security Number

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Secondary Insurance Policy Holder’s Name Policy Holder’s Social Security Number

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Tertiary Insurance Policy Holder’s Name Policy Holder’s Social Security Number

**Please read the following Authorizations carefully.**

**Medical Release:** I authorize Randolph Primary Care. PA to pull my pharmacy history for my records. I hereby authorize Randolph Primary Care, PA to receive any PHI necessary for my healthcare needs.

**Authorization to Release Information**: I authorize Randolph Primary Care, PA to release any information acquired in the course of my examination or treatment to my insurance company, Worker’s Compensation carrier or their representatives.

**Acceptance of Financial Responsibility**: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another at fault. Also, if this is a work related injury and the Worker’s Compensation carrier denies payment, I understand I am responsible for these charges. I hereby authorize payment directly to Randolph Primary Care, PA of any medical benefits.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (patient/responsible party)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_