ADVANCED RHEUMATOLOGY

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ADULT PATIENT REGISTRATION FORM

(Please Print)

PERSONAL INFORMATION

Name: _____ Street Address: _____

City: _____ State: _____ ZIP: _____ Email: _____

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

Soc Sec #: _____ Sex: _____ Marital Status: _____ Date of Birth: _____

Your Employer: _____ Emergency Contact Name: _____

Emergency Contact Phone: _____ (Circle One) Home Cell Work Relationship to Patient: _____

Primary Care Physician: _____ PCP Phone: _____

Preferred Retail Pharmacy (include location): _____

Preferred Mail Order Pharmacy: _____

INSURANCE INFORMATION

(All Insurance Cards Must Be Presented When Checking In For First Appointment)

PRIMARY CARRIER: _____

Subscriber or Contract #: _____ Group #: _____

Referral Authorization # (if required): _____ Co-Pay Amount (if any): $ _____

☐ I am the policy owner/main subscriber ***(skip info in box below if you are the policy owner/main subscriber)***

☐ I am covered under another person's policy Policyholder's Name: _____

Policyholder's Date of Birth: _____ Relationship to Patient: _____

Policyholder's Billing Address: _____

SECONDARY CARRIER: _____

Subscriber or Contract #: _____ Group #: _____

Referral Authorization # (if required): _____ Co-Pay Amount (if any): $ _____

☐ I am the policy owner/main subscriber ***(skip info in box below if you are the policy owner/main subscriber)***

☐ I am covered under another person's policy Policyholder's Name: _____

Policyholder's Date of Birth: _____ Relationship to Patient: _____

Policyholder's Billing Address: _____