

PRE-REGISTRATION FORM
PATIENT INFORMATION

SECTION I

NAME: _____ BIRTH DATE: _____
ADDRESS: _____ AGE: _____
CITY/STATE/ZIP: _____ RACE: _____
TELEPHONE #: _____ SOCIAL SECURITY #: _____ RELIGION: _____
STATUS: SINGLE MARRIED SEP. DIV. MAIDEN NAME _____
ARE YOU IN SCHOOL: YES NO NAME OF SCHOOL/ADDRESS _____
DO YOU WORK: YES NO FULL TIME PART TIME
EMPLOYER _____ HOW MUCH DO YOU MAKE A MONTH: _____
EMPLOYER ADDRESS _____
OCCUPATION _____ HOW MANY PEOPLE ARE SUPPORTED BY
TYPE OF MEDICAL INSURANCE: _____ THIS INCOME: _____
PERSON RESPONSIBLE FOR PAYING BILL: _____ IN CASE OF MEDICAL EMERGENCY CONTACT:
NAME: _____ NAME: _____
RELATIONSHIP: _____ RELATIONSHIP: _____
ADDRESS: _____ ADDRESS: _____
TELEPHONE #: _____ TELEPHONE #: _____

AGENCY USE ONLY - RECEPTIONIST

DATE: _____ APPT. TIME _____ TIME IN _____ TIME OUT _____
COMPUTER #: _____ MEDICAL RECORD# _____ INIT. _____ ANN. _____ 6 MON _____ R/V
CONTACT INSTRUCTIONS: _____
INSURANCE INFORMATION:
MEDICARE: _____
MEDICAID I.D. #: _____ SEQUENCE #: _____
MEDICAID MANAGED CARE: YES NO
PRIMARY PHYSICIAN NAME/ADDRESS: _____

BLUE CROSS: _____
BLUE SHIELD: _____ EFFECTIVE DATE: _____
OTHER INSURANCE: _____

AGENCY USE ONLY - COUNSELOR/TECHNICIAN

PAYMENT CODE: _____ DIAGNOSIS CODE: _____ NEW CODE: YES NO
LABS: PAP URINE C & S
 CHLAMYDIA (CA) (BGH) HERPES CULTURE
 RPR/SEROLOGY SERUM HCG QUANT. HCG
 RUBELLA TITRE LIPID PROFILE
 CBC CBC/DIFF FASTING GLUCOSE 2 HR P.P.
 SICKLE CELL OTHER: _____
 GC _____

AGENCY USE ONLY

NEXT VISIT DUE: _____
REFERRALS: CLINIC: _____
APPOINTMENT DATE: _____
APPOINTMENT TIME: _____
DATE APPOINTMENT MAILED TO PATIENT: _____