EASTWAY
Medical Clinic

New Patient Registration Form

Fields identified with an (*) must be completed

1. Demographic/ General Information

Patient's Name * First Name	Middle Name	Last Name
Gender Select one	**Date of Birth** MM/DD/YY	**SSN** Social security number
Marital status Select one		
Home Address * Address 1	Address 2	
City * City of residence	**State** Select one	**Zip** Patient's postal code
Email * Patient's email address		
Main Phone Number * xxx-xxx-xxxx	**Mobile Number** xxx-xxx-xxxx	**Work Phone Number** xxx-xxx-xxxx
Pharmacy Name Preferred pharmacy name	**Pharmacy Phone** Preferred pharmacy phone number xxx-xxx-xxxx	
Pharmacy address Preferred pharmacy address or street		
Emergency Contact Name Name of emergency contact person	**Relationship** Relationship of emergency contact with the patient	

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Phone Number Emergency contact phone number in xxx-xxx-xxxx	**Ethnicity/Race** Select one	**Language** Patient's language

2. Insurance Information

Insurance Subscriber's Name* First Name	Middle Name	Last Name
Relation * Patient Relationship with insurance subscriber	**Date of Birth** MM/DD/YYY	**SSN** Social security number for insurance subscriber

3. Responsible Party

Responsible Person Name * Name of the person	**Responsible Party *** Responsible party	
Date of Birth * MM/DD/YYYY	**SSN *** Social security number for responsible person	**Phone Number *** Phone number of the responsible party in xxx-xxx-xxxx
Mailing Address* Responsible party's city of residence		
City * Responsible party's state	**State *** Select one	**Zip *** Responsible party's postal code
Primary Insurance	**Secondary Insurance**	

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4. Worker Compensation Authorization

Employer's Name * Patient's employer name		**Phone** * Employer phone number in xxx-xxx-xxxx
Address * Employer's address		
City Responsible party's city of residence	**State** Select one	**Zip** Employer's postal code
WC Carrier Patient workers compensation carrier		**Phone** WC's carrier phone number in xxx-xxx-xxx
Claim No Patients claim number		**Address** WC carrier address
City Responsible party's state	**State** Alabama	**ZIP** Responsible party's postal code
Date of Injury MM/DD/YYY	**Employer Contact** Employer's contact of patient	**Drug Screen Required?** Yes/No

Patient Signature *

Agreement Statement *

☐ I clearly understand and agree that all services rendered to me will be charged directly to me in the event that worker's Compensation Benefits are denied.