



Mary T. Pentel, M.D.

PATIENT REGISTRATION FORM

checkboxes for New patient, Name change, Address Change, Insurance change

Patient Information (please print and fill out completely)

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ Marital Status: [ ] Single [ ] Married [ ] Other

Telephone (cell): \_\_\_\_\_ Primary Physician (PCP): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: [ ] M [ ] F

Employer: \_\_\_\_\_ Telephone (work): \_\_\_\_\_

E-mail address: [grid]

Would you like to receive special offers, news, and events via e-mail? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Telephone: \_\_\_\_\_

In case of Emergency Notify: \_\_\_\_\_ Telephone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_

Primary Insurance

Insurance Name: \_\_\_\_\_ Co-payment \$: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group or Plan Number: \_\_\_\_\_

Secondary Insurance

Insurance Name: \_\_\_\_\_ Co-payment \$: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group or Plan Number: \_\_\_\_\_

Responsible Party

Person responsible for payment (please circle): Self Spouse Father Mother Other

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please present insurance cards and a photo identification (driver's license) to the receptionist so copies may be made. Do we have your permission to:

Leave a message on your answering machine at home? [ ] yes [ ] no

Leave a message at your place of employment? [ ] yes [ ] no

Discuss your medical condition with any member of your household? [ ] yes [ ] no

If yes, whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature

Date