Collegeville Office

555 2nd Avenue, D-204
Collegeville, PA 19426

P: 610-454-1177
F: 610-454-0416

Lancaster Office

15 S. State Street, Suite 104
Brownstown, PA 17508

P: 717-661-1055
F: 610-454-0416

PATIENT REGISTRATION FORM
Please print

Patient Name: ____ **Date of Birth:** _____________ **Gender:** M / F

Mailing Address: ____

City: ____ **State:** _______________________________ **Zip Code:**_____________

Home Phone #: _____________________ **Work Phone #:** ______________________ **Cell Phone #:** ____________________

Email Address: ____

Occupation: ____ **Employer:** ____

Spouse: ____ **Spouse Contact Number:** ___________________________

Emergency Contact: ________________________________ **Phone #:** _____________________**Relationship:** _____________

Name of Parents/Guardians (if patient is under 18 years old): ____

Address if different from above: ____

Primary Care Physicians Name: ____**Phone #:**___________________________

Address: ____

Referring Physician: ____ **Phone #:** ___________________________

How did you hear about our office? ____

INSURANCE AND BILLING INFORMATION

1. Primary Insurance Company: ______________________________________ **Subscriber:** ________________________

Date of Birth of Policy Holder: _____________________________**ID #:** _________________ **Group #:** ____________

2. Primary Insurance Company: ______________________________________ **Subscriber:** ________________________

Date of Birth of Policy Holder: _____________________________**ID #:** _________________ **Group #:** ____________

CO-PAYMENTS ARE REQUIRED AT THE TIME OF SERVICE BY CASH, CHECK, OR CREDIT CARD

Patient Signature:____ Date:______________________________

Parent/Guardian (please print)_____________________________________Signature:___________________________