

Peter A. Kelt, M.D.
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PATIENT INSURANCE REGISTRATION FORM

PATIENT'S NAME _____ SOCIAL SECURITY # _____
(Last, First, Middle Initial)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (Home) _____ PHONE (Daytime) _____ PHONE (Cell) _____

EMAIL _____ DATE OF BIRTH _____ SEX (circle): MALE FEMALE MARITAL STATUS (circle): S / M / D / W

***THE FOLLOWING MUST BE INDICATED SINCE THEY ARE GOVERNMENT MANDATED QUESTIONS**

***RACE (circle):** AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER WHITE

***ETHNICITY (circle):** HISPANIC NON-HISPANIC PREFERRED LANGUAGE: _____

PRIMARY CARE PHYSICIAN NAME: _____ PHONE# _____
(as stated on insurance card if applicable)

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ SPOUSE'S PHONE _____ SPOUSE'S DATE OF BIRTH _____

SPOUSE'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY INFORMATION (circle) SELF SPOUSE CHILD PARENT STUDENT OTHER IF NOT SELF, COMPLETE FIELDS BELOW;

NAME (Last, First) _____ TELEPHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT: _____ PHONE: _____ CELL: _____

RELATIONSHIP TO PATIENT _____ ADDRESS OF CONTACT _____

INSURANCE INFORMATION (Please write information about patient's insurance here.)

PRIMARY INSURANCE CO. NAME _____ SECONDARY INSURANCE CO. NAME _____

INSURED'S ID NO. _____ INSURED'S ID NO. _____

GROUP PLAN NO. _____ GROUP PLAN NO. _____

INSURANCE CO. ADDRESS _____ INSURANCE CO. ADDRESS _____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO INSURED _____

NAME OF INSURED _____ NAME OF INSURED _____

ADDRESS OF INSURED _____ ADDRESS OF INSURED _____

D.O.B. OF INSURED _____ SEX OF INSURED _____ D.O.B. OF INSURED _____ SEX OF INSURED _____

TERTIARY INSURANCE _____

PHARMACY NAME _____ ADDRESS _____

PHONE NUMBER _____ PHARMACY FAX _____

HOW WERE YOU REFERRED TO OUR OFFICE? (CIRCLE): SELF/ANOTHER PATIENT/WINTHROP EMERGENCY ROOM/EMPLOYER/DOCTOR/OTHER (please explain)

IF REFERRED BY OTHER, PLEASE EXPLAIN _____

IF REFERRED BY A DOCTOR; PLEASE NAME _____

IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE RECEPTIONIST FOR APPROPRIATE FORMS...

DID INJURY OCCUR AT SCHOOL? (circle): YES NO WAS INJURY A SCHOOL SPORT? (circle): YES NO NAME OF SPORT: _____

DATE OF INJURY: _____ SCHOOL NAME: _____ SCHOOL PHONE#: _____

SCHOOL INSURANCE CARRIER NAME: _____

SCHOOL INSURANCE ADDRESS: _____ CITY, STATE & ZIP: _____

X

PATIENT (or authorized signature)

DATE