

Patient Registration Form

Jefferson Primary Care

116 East Third St.

Ranson, WV 25438

304-724-7200

Please give the receptionist your photo I.D. and current insurance card(s)

Patient Information:

Patient Name: _____ Nickname: _____ DOB: ___/___/___
Patient SSN: _____ - _____ - _____ Sex: M ___ F ___ Marital Status: M ___ S ___ D ___ W ___ Age: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Home phone: (_____) _____ E-mail Address: _____
Employer: _____ Work phone:(_____) _____ Cell phone: (_____) _____
Primary Care / Referring Doctor: _____ ph.#:(_____) _____

Spouse Information (or Parent, if applicable):

Name: _____ DOB: ___/___/___ SSN: _____ - _____ - _____
Address: _____ City: _____ State: _____
Zip Code: _____ Home phone: (_____) _____ E-mail Address: _____
Employer: _____ Work phone:(_____) _____ Cell phone: (_____) _____

Primary Insurance Information:

Insurance Co. Name: _____ Phone No.: (_____) _____
Address, City, State & Zip Code: _____
Policy ID#: _____ Group #: _____
Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN: _____ Does your plan require referral? _____ Copay Amount: \$ _____

Secondary Insurance Information:

Secondary Ins. Co. Name: _____ Phone No.: (_____) _____
Address, City, State & Zip Code: _____
Policy ID#: _____ Group #: _____
Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN: _____ Does your plan require referral? _____ Copay Amount: \$ _____

Accident Information:

Date: _____ Time Of Day: _____ am/pm Location/Where: _____
How/What Happened: _____

Is this a worker's compensation claim? Yes No If yes, please complete Worker's Compensation Registration Form

Patient/Guardian Signature: _____ Date: ___/___/___