Marshfield Medical Center
Beaver Dam

Registration Information

Thank you for coming to see us. You can speed your care by providing the following necessary information. When finished, please give this to the receptionist. This information will then go into our computer for future visits. Thank you.

Please **PRINT** and fill out this form **COMPLETELY**.

Date: _____

PATIENT:

_____ _____ _____
First name Middle Initial Last Name

_____ _____
Previous Names (AKA) Email Address

_____ _____ _____ _____
Street Address City State Zip Code

Phone: ( )_____-_____ Cell: ( )_____-_____ Birth Date:_____/_____/_____ SS#:_____-____-____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Hispanic ☐ Indian ☐ Black/African-American ☐ White ☐ Unknown ☐ Other:_____

Are you seeking a family physician? ☐ Y ☐ N If not, who is your family physician?: _____

Reason for visit: _____

Date symptoms began? _____

Employer:_____ Work Phone: ( )_____-_____

_____ _____ _____
Street Address City State Zip Code

Preferred pharmacy: _____ Phone: ( )_____-_____

RESPONSIBLE PARTY: if other than patient.

_____ _____ _____ _____
First Name Middle Initial Last Name Relationship to patient

_____ _____ _____ _____
Street Address City State Zip Code

Birth Date:_____/_____/_____ SS#:_____-_____-_____ Home Phone: ( )_____-_____

Employer:_____ Work Phone: ( )_____-_____

IN CASE OF EMERGENCY CONTACT:

Name:_____ Relationship _____

Home Phone: ( )_____-_____ Work Phone: ( )_____-_____

INSURANCE: Provide the following information if we will be filing your insurance. Any applicable copayments will be required at the time of service. Failure to meet your copay requirement may result in the need for rescheduling of your appointment. Please have cards available for copying.

PRIMARY INSURANCE:

Subscriber Name (If other than patient):_____ DOB:_____ Policy #: _____

Group Name:_____ Group#: _____

Mail claims to:_____ Phone: ( )_____-_____

_____ _____ _____ _____
Street Address City State Zip Code

SECONDARY INSURANCE:

Subscriber Name (If other than patient):_____ DOB:_____ Policy #: _____

Group Name:_____ Group #: _____

Mail claims to:_____ Phone: ( )_____-_____

_____ _____ _____ _____
Street Address City State Zip Code

Copayment:_____ Coinsurance (%):_____ Have you met your deductible? _____

PLANNED PAYMENT METHOD: As part of your responsibility, we ask for copayments and for some services, prepayment if needed, at the time of service. If paying by CHECK or CREDIT CARD, please provide your Driver's License number.