WINMED
—HEALTH—

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

DEMOGRAPHICS -PLEASE PRINT CLEARLY

Patient First/Last Name: _____ Date of Birth: _____ Mailing

Address: _____ City/State/Zip: _____ Home Phone:

_____ Cell Phone: _____ MALE/FEMALE_____ Social Security #:

_____ - _____ - _____ Email address_____

Marital Status: __Single __Married __Divorced __Widowed __Separated

PURPOSE OF VISIT_____ SYMPTOMS/EXPOSURE_____

INSURANCE

Insurance: _____ Member ID Number:_____

POLICY HOLDER FULL NAME _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____ Secondary

Insurance: _____ Policy Number: _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

MEDICAL HISTORY

Past Medical history: _____ Past surgical history: _____

Significant family history: None

Mother _____ Father _____ Other _____ Social History

(Circle): Alcohol, Tobacco, Current smoker, Former smoker

Allergies:_____ Current

medications:_____ This registration form

is to serve as an expedited registration form for a non-establishing visit. I understand that if I am using my insurance, it will be verified and billed according to the office visit. For full office policies please visit www.windermeremedicalcenter.com

CONSENT TO TREAT

NAME_____ DATE_____

SIGNATURE_____