New Tripoli Whole Health
6505 Route 309
New Tripoli, PA 18066
610-298-8029

Registration

Today's Date:

Please print all information and sign below.

PATIENT INFORMATION					
Patient Name:	Birth Date:	Age:	Sex:	Social Security #	
Street Address:	City:		State:	Zip:	
Home Phone:	Cell Phone:	Work Phone:	Fax:		
Occupation:	Employer:	Employer's Phone (if work related):			
Marital Status:	Spouse's Name:	Number of Children:			
Emergency Contact:	Relationship to Emergency Contact:	Emergency Contact Phone Number:			

INSURANCE INFORMATION			
Please give your insurance card to the receptionist so that we may make a copy for our records.			
Insurance Company:	ID #	Group #	
Subscriber's Name:	Relationship to Patient: ☐Self ☐Spouse ☐Other	Birth date:	Social Security #
Subscriber's Address:			Subscriber's Phone #

ACCIDENT INFORMATION (if applicable)	
Is Condition Accident Related: ☐yes ☐no	Type of Accident: ☐Auto ☐Work ☐Home ☐Other Date:
Who have you reported the accident to: ☐Auto insurance ☐Employer ☐ Worker Compensation ☐ Other	
Accident description:	
Attorney's Name:	

ADDITIONAL INFORMATION		
Primary Care Physician:	Group Name:	Location:
Date of last exam:	Whom may we thank for referring you:	
Your Email Address:		

SIGNATURE ON FILE

The above information is true to the best of my knowledge. I understand that I am completely responsible for my bill. I authorize New Tripoli Whole Health to release my healthcare information to the above listed insurance company. In the case of Medicare, Medicaid, Workers Compensation, I also authorize payment directly to New Tripoli Whole Health for services rendered.

_____ _____ _____

Print Patient's or Representative's Name | Sign Patient's or Representative's Name | Date