Wall & Howell Family Medical
Patient Registration Information
When completed please email to partnersinfreedomnj1@gmail.com

Name: Last First MI		Nickname/Maiden Name	Spouse's Name
Street Address		☐ Male ☐ Female	☐ Married ☐ Single ☐ Divorced ☐ Widowed
City, State, Zip		Date of Birth _____Mo _____Day _____Yr	
Home Phone ( )	Work Phone ( )	Social Security #	
Name of your Primary Care Physician:		Email Address:	

Patient's Employer Information

Company Name	Company Address
Company Phone ( ) Ext.	City, State, Zip

IF PERSON RESPONSIBLE FOR PAYMENT IS SOMEONE OTHER THAN PATIENT, COMPLETE SECTION B. PATIENT GO TO SECTION C

Section B: Responsible Party Information

Name: Last First MI		Relationship to Patient:
Street Address		Responsible Party's Employer's Name (Company)
City, State, Zip		Company Address
Date of Birth: ___Mo ___Day _____Yr	Social Security #	City, State, Zip
Work Phone ( )	Home Phone ( )	Company Phone ( )
Marital Status ☐ M ☐ S ☐ D ☐ W		

Please provide insurance information. Include secondary insurance information if applicable.

Section C: Insurance Information

Primary Insurance:		**Secondary Insurance:**	
Insurance Company Name		Insurance Company Name	
Policy ID Number	Group #	Policy ID Number	Group #
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Date of Birth	Policy Holder's Social Security #	Policy Holder's Date of Birth	Policy Holder's Social Security #
Policy Holder's Relationship to Patient		Policy Holder's Relationship to Patient	

IN CASE OF EMERGENCY CONTACT:

Name Last First MI	Relationship to Patient:
Work Phone ( ) Cell Phone ( )	

RELEASE AND ASSIGNMENT: "I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and Commercial insurance to Partners In Freedom LLC d/b/a Wall & Howell Family Medical. I understand that I am financially responsible for all charges that are not covered by said insurance. I hereby authorize said assignee to release any information necessary to secure payment on my behalf."

Patient or Legal Guardian

Signature_____ **Date**_____