REGISTRATION

PATIENT INFORMATION (CONFIDENTIAL)

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONTACT NUMBERS:
HOME PHONE: _____ CELL: _____ WORK: _____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT:
NAME: _____ PHONE #: _____ RELATIONSHIP: _____

ELIGIBILITY

RETIRED: ☐ YES IF *YES*, ARE YOU A RETIRED TEAMSTER? ☐YES ☐ NO

☐ NO IF *NO*, PLEASE LIST INSURANCE INFORMATION BELOW

PRIMARY INSURANCE INFORMATION

☐ WHF PLAN

☐ OTHER INSURANCE (PLEASE COMPLETE ALL INFORMATION BELOW):

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ PHONE: _____

NAME OF EMPLOYER: _____ WORK PH: _____

INSURANCE COMPANY: _____ PHONE: _____ GROUP #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

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SECONDARY INSURANCE INFORMATION

☐ WHF PLAN

☐ OTHER INSURANCE (PLEASE COMPLETE ALL INFORMATION BELOW):

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ PHONE: _____

NAME OF EMPLOYER: _____ WORK PH: _____

INSURANCE COMPANY: _____ PHONE: _____ GROUP #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

X _____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**