Main Line HealthCare
Physician Network

Patient Registration Form

Today's Date_____

Please complete this form in order to ensure proper billing of your services. PLEASE PRINT

Patient Demographic Information	
Name	Date of Birth:
Legal Name:	Sex assigned at Birth: ☐ Male ☐ Female ☐ Unknown
Address:	Gender Identity:
Address:	Pronoun: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs
City: State: Zip:	Home Phone:
Marital Status: Single Married Widowed Separated Divorced Other	Cell Phone: Work Phone: Email:
Preferred Language:	Preferred Contact: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ MyChart
Ethnicity: ☐ Not Hispanic, Latino/a or Spanish origin ☐ Hispanic, Latino/a or Spanish origin ☐ Unknown ☐ Decline to Answer	Race: *(Response is not mandatory. Data is used for statistical reporting.)* **Please choose all that apply.** ☐ Black/African American ☐ White ☐ Hispanic ☐ Chinese American ☐ Japanese American ☐ Filipino American ☐ Other Asian ☐ American Indian/Alaska Native ☐ Other Pacific Islander ☐ Native Hawaiian ☐ Decline to Answer ☐ Unknown ☐ Other
Primary Care Provider:	Referring Provider:
Other Treating Providers (Name/Specialty):	
Are you visually impaired? ☐ Yes ☐ No Are you hearing impaired? ☐ Yes ☐ No Do you need an interpreter? ☐ Yes ☐ No	

Emergency Contact Information	
Name:	Relationship to Patient:
Address:	Home Phone:
Address:	Work Phone:
City:	Cell Phone:
State: Zip:	

Guarantor Information *Please complete if guarantor is other than self. The guarantor is the person financially responsible for this patient's bill.*	
Name:	Relationship to Patient:
Address:	Guarantor Date of Birth:
Address:	Home Phone:
City:	Work Phone:
State: Zip:	Cell Phone:

Insurance Information **A separate form is required for Worker's Compensation, Automobile Liability, or Legal services.*	
Primary Carrier:	Subscriber Name:
Insurance Address:	Relationship to Patient:
Telephone #:	Subscriber Date of Birth:
Effective Date:	Subscriber Employer:
ID/Cert#: Group Name/Plan:	
Secondary Carrier:	Subscriber Name:
Insurance Address:	Relationship to Patient:
Telephone #:	Subscriber Date of Birth:
Effective Date:	Subscriber Employer:
ID/Cert#: Group Name/Plan:	

Do you have a healthcare power of attorney? ☐ Yes ☐ No Do you have a living will? ☐ Yes ☐ No
How did you hear of our practice?
*Is this visit a result of an accident (Auto/Worker's Comp/Personal Injury)? ☐ Yes ☐ No
Pharmacy Name: City: Telephone#: