BURLINGTON MEDICAL CENTER / CAROLINA NUCLEAR MEDICINE
PATIENT REGISTRATION FORM

First Name: _______________________________________ **MI:** ________ **Last Name:** ____

Home Address: ____

Home Phone: ______________________________________ **Cell Phone:** ____

Date of Birth: __________________________ **Sex:** ____**M** ____ **F** **Social Security Number:** ______________________________________

Marital Status: ___**Married** ___**Single** ___**Divorced** ___**Widowed** **Employment status:** ___**Employed** ___**Retired** ___**Student**

Employer: ____ **Work Phone:** ____

Referring Physician: ____ **How did you hear of us?** ______________________________________

Primary Pharmacy: ____ **Phone #:** ____

INSURANCE INFORMATION: - PLEASE PROVIDE YOUR INSURANCE CARDS TO THE RECEPTIONIST

Primary Insurance Company: ____

Insured/Card Holder's Name: ____ Relationship: ____

ID#: ____ Group#: ____

Secondary Insurance Company: ____

Insured/Card Holder's Name: ____ Relationship: ____

ID#: ____ Group#: ____

Emergency Contact: ____

Relationship to patient: ____

Home Telephone: ____ **Cell Phone:** ____

AUTHORIZATION TO DISCUSS PATIENT INFORMATION

Is there anyone you would like to authorize to receive your medical information?

Name: ____ Relationship: ____

Name: ____ Relationship: ____

SIGNATURE: ____ Date: __________________________________