# New Patient Registration Form

| 169 Rawls Road<br>Angier, NC 27501<br>919-331-2001 | 1301 Medical Drive<br>Fayetteville, NC 28304<br>910-486-5700 |
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## PATIENT INFORMATION

First - Middle- Last Name:________________________________________________

Title:________________________Gender:___________Birth Date:______________

Street Address:_________________________________________________________

City:______________________________State:____________ Zip code:__________

Social Security Number:_____________________Email Address:________________

Relationship to Responsible Party:__________________________________________

Home phone: (___)________________Cell Phone: (____)______________

Work phone: (____)______________

Primary Care Physician:______________________________________

Employer:__________________________________________________

Emergency contact:____________________________________________

Emergency Contact Phone: (_______)______________________________

Pharmacy:__________________________________________________

Pharmacy Phone: (___)________________________________________

## PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18

First - Middle- Last Name:________________________________________________

Title:________________________Gender:_________________Birth Date:_________

Street Address:______________________________________________

City:______________________________State:______________Zip code:______________

Social Security Number:______________________

Home Phone: (______)________________________

Employer:__________________________________

Work Phone: (______)________________________

## PRIMARY COVERAGE

Insurance Company Name:_____________________________________

Effective Date:______________________________________________

ID number:_________________________________________________

Group Number:______________________________________________

Subscriber Name (Person that Holds the Insurance):____________________________

Subscriber Birth Date:____________Subscriber Social Security Number:_____________

Subscriber Employer: ____________________________________

Pt Relationship to Subscriber:______________________________

Insurance Claim Address: ______________________________________________

City:______________________________State:__________ Zip code:__________

Phone:______________________________

## SECONDARY COVERAGE

Insurance Company Name:_____________________________________________

Effective Date:________________________

ID number:___________________________

Group Number:________________________

Subscriber Name (Person that Holds the Insurance):______________________________

Subscriber Birth Date:____________Subscriber Social Security Number:_____________

Subscriber Employer: ________________________________________

Pt Relationship to Subscriber:_____________________________________

Insurance Claim Address: ________________________________________________

City: ___________________________State:___________Zip code:_________________

Phone: _________________________