Medical Center
Gregory Singer, MD, PC
227 S. Route 100
Allentown, PA 18106

Patient Registration Form

Patient Information

Last Name: ______________________ First Name: ______________ MI: ____

Previous Name: ______________________

DOB: ______________ SSN: ______________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated

Mailing Address: ______________________________________

City: ______________________ State: ______ Zip: ________

		May we leave a detailed message regarding your medical care / treatment at this number?
Home Phone:	( ) -	☐ Yes ☐ No
Cell Phone:	( ) -	☐ Yes ☐ No
Work Phone:	( ) -	☐ Yes ☐ No

Employer Information

Employer: ______________________________

Address: ______________________________

Phone: ______________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

Race (required)	Ethnicity (required)	Primary Language (required)
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other race ☐ Refused to Report	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report	☐ English ☐ Spanish ☐ Other ____________

Emergency Contact

Name: ______________________ Relationship to patient: ______________________

Mailing Address: ______________________ City: ______________ State: ______ Zip: ______

Phone Number: ( ) - ______________

Minor's Only (Under age 18)

Mother's Name: ____________ Address: ____________ Phone: ________

Mother's Employer: ____________ Work Phone: ____________

Father's Name: ____________ Address: ____________ Phone: ________

Father's Employer: ____________ Work Phone: ____________

Pharmacy Information

Pharmacy of Choice: ____________

Address/Location: ____________

Miscellaneous Information

How did you Hear about our Office? ____________

Who is your Primary Care Physician? ____________

Referred By: ____________

Spouse's Information

Last Name: ____________ First Name: ____________ MI: ____

Mailing Address: ____________ City: ____________ State: ____ Zip: ______

Contact Phone #: (   )   -

Employer: ____________ Employer Phone #: (   )   -

Insurance Information

Please be prepared to show your insurance card and identification at every office visit.

Primary Insurance Company: ____________

Policy Holder's Name ____________ SS#: ____________ DOB: ________

Policy/ID Number: ____________ Group #: ____________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Secondary Insurance Company: ____________

Policy Holder's Name ____________ SS#: ____________ DOB: ________

Policy/ID Number: ____________ Group #: ____________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Assignment of Benefits/Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to the Medical Center of Gregory Singer, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this shall be as valid as the original.

____

Patient Name (please print)

____________________________ ____________

Patient Signature Date