Penn Medicine

PATIENT REGISTRATION QUESTIONNAIRE

Update ☐ *New* ☐

In order to keep your records up to date, please answer the following questions on both sides of the form.

LOCATION	PATIENT IDENTIFICATION NUMBER/MRN	TEMPORARY ACCT. NUMBER	VERIFIED BY/DATE

NAME OF PATIENT

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER

DATE OF BIRTH SEX: M F

EMERGENCY CONTACT

( )

AREA CODE EMERGENCY CONTACT TELEPHONE

FATHER'S NAME: _____ MOTHER'S NAME: _____

MAIDEN NAME: _____

RACE: * Arab: _____ Asian: _____ Black: _____
Caucasian: _____ Hispanic: _____ Indian: _____
Other: _____

MARITAL STATUS:* Married _____ Single _____ Divorced _____
Widowed _____ Separated _____ Other _____

*It is not mandatory to answer this question. However for statistical purposes, your answers would be appreciated.

GUARANTOR INFO (IF DIFFERENT THAN PATIENT)

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER

DATE OF BIRTH SEX: M F

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

RELATIONSHIP TO GUARANTOR

( )

AREA CODE

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE TELEPHONE

PATIENT ADDRESS

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE HOME TELEPHONE

( )

AREA CODE DAY TELEPHONE

EMAIL ADDRESS

PATIENT EMPLOYMENT INFORMATION

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE TELEPHONE

OCCUPATION

PRIMARY CARE/FAMILY PHYSICIAN

MD DO

NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )

AREA CODE TELEPHONE

COMMENTS:

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
PATIENT REGISTRATION QUESTIONNAIRE

PATIENT NAME

PATIENT IDENTIFICATION NUMBER/MRN

PRIMARY INSURANCE (please "✓" the appropriate box below)

☐ BC/BS ☐ Commercial ☐ HMO/PPO ☐ POS

NAME OF INSURANCE CO.

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

CERTIFICATE NUMBER

GROUP NUMBER

PLAN NUMBER MEDICARE PLAN? Y or N

EFFECTIVE DATE EXPIRATION DATE

( )
AREA CODE TELEPHONE

SUBSCRIBER NAME (IF DIFFERENT)

RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER'S BIRTHDAY

SUBSCRIBER'S SEX: M or F

SECONDARY INSURANCE (please "✓" the appropriate box below)

☐ BC/BS ☐ Commercial ☐ HMO/PPO ☐ POS

NAME OF INSURANCE CO.

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

CERTIFICATE NUMBER

GROUP NUMBER

PLAN NUMBER MEDICARE PLAN? Y or N

EFFECTIVE DATE EXPIRATION DATE

( )
AREA CODE TELEPHONE

SUBSCRIBER NAME (IF DIFFERENT)

RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER'S BIRTHDAY

SUBSCRIBER'S SEX: M or F

MEDICAL ASSISTANCE

RECIPIENT NUMBER

CARD ISSUE NUMBER

MANAGED CARE/MEDICAL ASSISTANCE PLAN NAME:

IDENTIFICATION NUMBER

MEDICARE *Please Answer Questions Below*

WORKER'S COMPENSATION/AUTO ACCIDENT INFO

(Please Circle Either Worker's Compensation or Auto Accident)

INSURANCE CARRIER'S NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( )
AREA CODE TELEPHONE

DATE OF INJURY/ACCIDENT

CLAIM NUMBER/POLICY NUMBER

MULTIPLE CLAIMS? Y or N

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER SEX

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

Medicare Questions (Please Circle Y or N)

Are you or your spouse employed?	**Y or N**
Do you or your spouse have other insurance?	**Y or N**
Are you disabled or have end stage renal disease?	**Y or N**
Is this illness or injury the result of an auto accident?	**Y or N**
Did this illness or injury occur at work?	**Y or N**
Has treatment been authorized by the V.A.?	**Y or N**
Are you covered under the Black Lung Program?	**Y or N**
Is there Medigap coverage secondary to Medicare?	**Y or N**
Is there employer supplemental insurance secondary to Medicare?	**Y or N**
Is there insurance coverage primary to Medicare?	**Y or N**