



REGISTRATION

PATIENT INFORMATION (CONFIDENTIAL)

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONTACT NUMBERS:
HOME PHONE: _____ CELL: _____ WORK: _____

EMERGENCY CONTACT:
NAME: _____ PHONE #: _____ RELATIONSHIP: _____

ELIGIBILITY

RETIRED: YES IF YES, ARE YOU A RETIRED TEAMSTER? YES NO
 NO IF NO, PLEASE LIST INSURANCE INFORMATION BELOW

PRIMARY INSURANCE INFORMATION

WHF PLAN

OTHER INSURANCE (PLEASE COMPLETE ALL INFORMATION BELOW):

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ PHONE: _____

NAME OF EMPLOYER: _____ WORK PH: _____

INSURANCE COMPANY: _____ PHONE: _____ GROUP #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE INFORMATION

WHF PLAN

OTHER INSURANCE (PLEASE COMPLETE ALL INFORMATION BELOW):

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ PHONE: _____

NAME OF EMPLOYER: _____ WORK PH: _____

INSURANCE COMPANY: _____ PHONE: _____ GROUP #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SIGNATURE OF PATIENT/GUARDIAN

DATE