William Cromwell, MD, FAHA, FNLA

Lipoprotein and Metabolic Disorders Institute, PLLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (check one) Single / Mar / Div / Sep / Widow ☐ ☐ ☐ ☐ ☐		
Preferred name:	Parent or responsible party (if patient is a minor):				
Birth date: / / mm dd yyyy	Age:	Sex: ☐ M ☐ F	Social Security no.: (Used for identification and billing purposes only)		
Home phone no.: (May messages be left: ☐ Yes / ☐ No) ( )	Cell phone no.: (May messages be left: ☐ Yes / ☐ No) ( )	Preferred daytime phone no.: ( )			
Home Street address:	Mailing Address (if different)				
City / State / Zip Code	City / State / ZIP Code				
Email: (This will be used for possible future correspondence. We will not "sell" your information)					
Occupation:	Employer:	Work phone no.: ( )			
Other family members seen here:					

Name	City	Phone	Fax
Primary physician:			
Referring physician:			
Preferred pharmacy			

Emergency Contact Person:	Relationship:	Phone no.: ( )

Persons authorized to receive information about my healthcare:

Name	Relationship	Phone no.:
1.		( )
2.		( )

I acknowledge that this authorization can only be rescinded by my written authorization.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Are you enrolled in Medicare? ☐ Yes / ☐ No	If not enrolled, are you eligible for Medicare? ☐ Yes / ☐ No
Medicare ID no.:	
Primary Insurance:	Secondary Insurance:
Insurance ID no.:	Insurance ID no.:
Group no.:	Group no.:
Policy Holders Name:	Policy Holders Name:
Policy Holders Date of Birth:	Policy Holders Date of Birth:

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment at the time of service as outlined in the financial policy statement. If I chose to file with my insurance I authorize Dr. Cromwell to release any information required to process my claims. I understand Dr. Cromwell has opted out of the Medicare program effective on July 1, 2011 for a period of at least two years. I understand that neither the patient nor Dr. Cromwell may file for Medicare or Medicaid payment.

_____ _____

Patient/Guardian signature *Date*

8300 Health Park Drive, Suite 316 Raleigh, NC 27615 Phone: 919-569-5971 Fax: 919-336-4732