Franciscan PHYSICIAN NETWORK

REGISTRATION FORM

Date: ____________

Patient Name: ______________________________ Sex: ☐ F ☐ M
Last First Middle

Social Security #: ____________ Birth Date: ____________

Address: ____________ ____________
Street/Apt # City / State / Zip Code

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Email Address: ____________ Language: ____________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(ed) Ethnicity: ________ Religion: ________ Race: ________

Primary Care Physician: ____________ Referring Physician: ____________

Preferred Pharmacy Name & Phone: ____________

Employer/School: ____________ Occupation ____________

Address: ____________ ____________
Street/Apt # City / State / Zip Code

Phone: ____________ Fax: ____________

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

---

Spouse's Name: ____________ Employer: ____________ Work Phone: ____________

Address: ____________

Phone: ____________ Work Phone: ____________ Mobile Phone: ____________

If patient is a minor, parent/legal guardian is: ____________ Relationship to patient: ____________

Emergency Contact ____________ Relationship to Patient ____________

Emergency Contact Home Phone ____________ Cell Phone ____________

WHO SHOULD RECEIVE THE BILL

Name: ____________ Relationship to Patient: ____________ Sex: ☐ F ☐ M

Social Security #: ____________ Birth Date: ____________ Phone: ____________

Address: ____________

Employer: ____________ Work Phone: ____________

Employer Address: ____________

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

---

MEDICAL INSURANCE INFORMATION

First (Primary) Insurance Co.: ____________

Insurance Co. Address: ____________

Policy Holder's Name: ____________ Relationship to Patient: ____________

Policy Holder's Birth Date: ____________ ID: ____________ Group/Policy #: ____________

Policy Holder's Employer: ____________ Social Security #: ____________

Effective Date: ____________

Secondary Insurance Co.: ____________

Insurance Co. Address: ____________

Policy Holder's Name: ____________ Relationship to Patient: ____________

Policy Holder's Birth Date: ____________ ID: ____________ Group/Policy #: ____________

Policy Holder's Employer: ____________ Social Security #: ____________

Effective Date: ____________

Vaccine Questions			
Circle any that apply to you:	Lung Cancer Asthma Smoker	Diabetic CHF COPD	
Have you ever had Guillain-Barre' Syndrome (GBS)?		YES	NO
Have you ever had a severe reaction or passed out after receiving a vaccination?		YES	NO
Are you allergic to Eggs or Egg products?		YES	NO

CPT Code	Vaccine	Manufacturer	Route	Lot# Expiration	Cpt Code	Vaccine	Manufacturer	Route	Lot # Expiration
90686	Fluarix/Flulaval Fluzone	GSK Sanofi	IM R or L Arm or thigh		90682	Flubok (egg free)	Sanofi	IM R or L	
90672	FluMist	AstraZeneca Medimmune	Nasal		90662	Fluzone High Dose	Sanofi	IM R or L	
90674	Flucelvax 4yr and Up	Seqirus	IM R or L Arm or Thigh		90694	Fluad 65yr or older	Seqirus	IM R or L	
90732	Pneumonvax 23	Merck	IM R or L		90670	Prevnar 13	Pfizer	IM R or L	
90750	Shingrix	GSK	IM R or L		90715	Tdap	GSK	IM R or L	
RN/LPN/MA signature					Date		EMR		Chirp