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	