Windermere Medical Center Quick Registration

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

DEMOGRAPHICS

Patient First/Last Name: _____ Date of Birth: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Social Security #: _____ - _____ - _____ Email address: _____

INSURANCE

Insurance: _____ Policy Number: _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

MEDICAL HISTORY

Past Medical history: ☐ None

_____

Past surgical history: ☐ None

_____

Significant family history: ☐ None

Mother _____ Father _____ Other _____

Social History: ☐ No Alcohol ☐ No tobacco

☐ Alcohol ☐ Current smoker ☐ Former smoker

Allergies: _____

Current medications: _____

This registration form is to serve as an expedited registration form for a non-establishing visit. I understand that if I am using my insurance, it will be verified and billed according to the office visit. For full office policies please visit www.windermeremedicalcenter.com

Please email completed form, driver's license and insurance card (if using) to NEWPATIENT@WINDERMEREMEDICALCENTER.COM