

## UNC MCLENDON CLINICAL LABORATORY PATIENT REGISTRATION FORM

### Patient Information

Last Name	First Name	MI
Employer	Soc. Sec.#	Date of Birth
Street Address		Apt. #
City	State	Zip
Home Phone	Work Phone	
Emergency Contact	Phone(new patients only)	

### Responsible Party Information

Last Name	First Name	MI
Employer	Soc. Sec.#	Date of Birth
Street Address		Apt#
Home Phone( )	Work Phone	
Relationship to Patient (Check One)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other	

### Insurance Policy Holder Information

Subscriber: Last Name	First Name	MI
Date of Birth	Employer Name	
Name of Insurance	Type of Insurance <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other	
Policy #	Effective dates of insurance coverage	
Group #	Mail Claims to (Address on ins. card):	
City	State	Zip
<b>Patient's</b> Relationship to the Policy Holder – (Check one)	<input type="checkbox"/> Patient <input type="checkbox"/> Step Child <input type="checkbox"/> Grand Parent <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Foster Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Natural Child <input type="checkbox"/> Ward of Court <input type="checkbox"/> Niece/ Nephew	

### Secondary Insurance Information

Subscriber: Last Name	First Name	MI
Date of Birth	Employer Name	
Name of Insurance	Type of Insurance <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other	
Policy #	Effective dates of insurance coverage	
Group #	Mail Claims to (Address on ins. card):	
City	State	Zip
<b>Patient's</b> Relationship to the Policy Holder – (Check one)	<input type="checkbox"/> Patient <input type="checkbox"/> Step Child <input type="checkbox"/> Grand Parent <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Foster Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Natural Child <input type="checkbox"/> Ward of Court <input type="checkbox"/> Niece/ Nephew	

**Note:** Physician must provide a diagnosis or ICD-9 code to support laboratory testing.