**Jacket Number**______________

# *Patient Registration Form*

## Patient Information

Patient Name (Last) ___________________________________(First)_______________________________ (MI)________

Sex _______ Date of Birth ____/____/____ Weight ________ Height ________ Social Sec. No. ____________________

Address: _________________________________City ___________________________ State_______ Zip___________

Home Phone: (____) ____________________Marital Status: __________ Work Phone: (_____)___________Ext.______

Student Status (Check One): ☐ Not a Student ☐ Full Time Student ☐ Part Time Student

## Employer Information

Employment Status (Check One): ☐ Employed Full Time ☐ Employed Part Time ☐ Self Employed

☐ Not Employed ☐ On Active Military Duty ☐ Retired

Employer Name_____________________________________________________________________________________

Address ________________________________ City ___________________________State __________Zip________

Phone (_____)____________________________________

## Emergency Contact

Name (Last)_____________________________________ (First)____________________________________________

Home Phone (____)_______________Work Phone (____)_____________Ext. _____ Relationship _______________

Address _________________________________________City______________________ State_______ Zip__________

## Primary Insurance Information

Group Number ___________________________________ID Number ________________________________________

Insurance Carrier ___________________________________________Phone (____)____________________________

Claims Address (include PO box) _____________________________City_____________________ State___ Zip______

Insured's Name (Last)_____________________________(First)___________________________________(MI)________

Insured's Address_________________________________City________________________State______Zip__________

Insured's Birth Date ____/____/____ Social Sec. No.__________________________ Phone (____)__________________

Insured's Employer___________________________ Work Phone (___)__________Ext._______ Relationship ________

Employer Address_________________________________City_______________________State_______Zip___________

**COMPLETE OTHER SIDE FOR RESPONSIBLE PARTY, SECONDARY OR ACCIDENT INSURANCE INFORMATION**

Revised 10/01/03

## Responsible Party (who pays the non-covered medical bills for this patient?)

Guarantor: Name (Last)________________________________ (First)________________________________(MI)____

Home Telephone (____)_________________ Work Phone Telephone (____)_________________ Ext.____________

Address ______________________________________City ___________________________State_____ Zip ________

Social Sec. No. _____________________________ Relationship to Patient: ________________________________

Employer Name________________________________________________________________________________

Employer Address ____________________________City______________________________ State_____ Zip________

## Secondary Insurance Information

**Is this a Medicare supplement? ______**

Group Number __________________________________ID Number__________________________________________

Insurance Carrier___________________________________________ Phone (____)____________________________

Claims Address (include PO box)____________________________City _____________________State ____ Zip______

Insured's Name (Last)__________________________________(First)_______________________________(MI)______

Insured's Address__________________________________City_________________________State_____Zip________

Insured's Birth Date ____/____/____ Social Sec. No. ___________________________ Phone (____)________________

Insured's Employer _______________________Work Phone (____)___________Ext. ______ Relationship___________

Employer Address__________________________________City________________________ State____ Zip________

## Work Related/Accident/Personal Injury Insurance

Check One: ☐ Employment ☐ Auto Accident ☐ Other Accident Injury Date: ___/___/___ State Where Injury Occurred: ____

Insurance Carrier_________________________________________ Phone (_____)_____________________________

Claims Address (include PO box)___________________________City ______________________State _____ Zip_____

Claim Number _____________________Claims Adjuster ________________________ Phone (_____) ______________

## If applicable:

Name of Attorney ________________________________________ Phone (_____) ____________________ Ext. _____

Address of Attorney ________________________________ City ______________________ State ______ Zip _______

**I hereby certify that all information in this Patient Registration form is true and correct**

______________________________________ ______________________________________ __________

Patient or Legal Representative Signature | Print Name and Authority (if legal representative) | Date