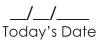
Patient Registration Form





A Department of Self Regional Healthcare Partners

Patient Demographics

<u>SELF</u>	K	L	_(J	I	J	1	١Ł	۱.	L	
	Н	Ε	Α	L	T	Н	С	Α	R	Е	
EDGEFIELD	٨	ΛE	ΕD	10	2	ΑI	L	CE	N	ΤE	R

Social Security #	Legal Last Name	Legal Fir	st Name	Middle Ir	nitial Pref	ferred First Name
Permanent Address	5	Αŗ	ot. #	City	State	e ZIP
Home Phone	Cell Phone			Preferred	l Provider / Primo	ary Care Physician
Birth Date	Lan	guage	Email .	Address		
Gender 🗆 Male 🗀 Fe			Status 🗖 Sin	gle 🔲 Married	I □ Divorced □ \	Widowed 🔲 Separated
Race 🗖 Black/African Ai	merican 🔲 Hispanic 🔲 White	☐ Other	Ethnicit	y 🔲 Hispanic/La	tino 🔲 Non-Hispanic/	'Non-Latino 🔲 Unknown
Preferred Communi	ication 🗖 Home 🗖 Cell 🗖	Work 🔲 Mail 🔲	Decline			
Emergency Con	tact Information					
Contact Name		Relationsh	nip to Conto	act	Con	tact Phone #
Contact Address		Ap	ot. #	City	State	e ZIP
Patient Employm	nent Information					
Employer	Employmer	nt Address		City	State	e ZIP
Occupation	Employmer	nt Contact	Phone	; #	Fax	#
Employment Pai	rt Time 🔲 Full Time	■ Not Emplo	yed 🗆 Se	f Employed	☐ Retired [⊒ Disabled
Student 🗀 Pai	rt Time 🔲 Full Time	■ Not a Stud	ent 🗆 Mi	litary		
Responsible Parl	ly's Information					
	•					
Responsible Party's	Legal Name			Social Sec	urity #	Date of Birth
Responsible Party's	Address	Ap	ot. #	City	State	e ZIP
Medical Insuran	ce Policy Holder Ir	nformation	Please pr	esent your in	surance card(s) &	So ID with this form.
	•		S	,	.,	,
Primary Insurance Carrier	Name		E Secondary	Insurance Carrier N	lame	
R Insured Name	Insured SSN II	nsured Birth Date	Insured Na		Insured SSN	Insured Birth Date
M Illisureu Name	IIISUIEU 33IV II	isureu birtii Date	N Illsuled No	anie	ilisuleu 33N	insured birtii Date
Address	C	ity/State/Z I P	A Address			City/State/ZIP
Phone #	Relationship	to Patient	Y Phone #		Relation	nship to Patient
	ease Information: I hereby horize payment directly to SMG for m					edical treatment to my
I Further Understand agents and other affiliates to pro	d and agree that: By signin ovide general care for this and all subsosts, that it incurs in connection with the	g below, either persona sequent requests for car	l l y or through the p e. SMG shall also be	erson legally empoventitled to the recove	vered to give consent, I auth ery of all its expenses, includ	ing all collection fees,
DO YOU WANT TO DESIGNA	TE A FAMILY MEMBER OR OTHE	R INDIVIDUAL WITH	WHOM THE PR	OVIDER MAY DISC	USS YOUR MEDICAL CO	NDITION? TYES NO
IF YES, WHOM?						
Signature					Date	