Patient Registration Form

__/__/____
Today's Date

SELF REGIONAL HEALTHCARE
EDGEFIELD MEDICAL CENTER
A Department of Self Regional Healthcare Partners

Patient Demographics

Social Security # | Legal Last Name | Legal First Name | Middle Initial | Preferred First Name

Permanent Address | Apt. # | City | State | ZIP

Home Phone | Cell Phone | Preferred Provider / Primary Care Physician

Birth Date | Language | Email Address

Gender ❑ **Male** ❑ **Female** Marital Status ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**

Race ❑ **Black/African American** ❑ **Hispanic** ❑ **White** ❑ **Other**_____ Ethnicity ❑ **Hispanic/Latino** ❑ **Non-Hispanic/Non-Latino** ❑ **Unknown**

Preferred Communication ❑ **Home** ❑ **Cell** ❑ **Work** ❑ **Mail** ❑ **Decline**

Emergency Contact Information

Contact Name | Relationship to Contact | Contact Phone #

Contact Address | Apt. # | City | State | ZIP

Patient Employment Information

Employer | Employment Address | City | State | ZIP

Occupation | Employment Contact | Phone # | Fax #

Employment ❑ **Part Time** ❑ **Full Time** ❑ **Not Employed** ❑ **Self Employed** ❑ **Retired** ❑ **Disabled**

Student ❑ **Part Time** ❑ **Full Time** ❑ **Not a Student** ❑ **Military**

Responsible Party's Information

Responsible Party's Legal Name | Social Security # | Date of Birth

Responsible Party's Address | Apt. # | City | State | ZIP

Medical Insurance Policy Holder Information

Please present your insurance card(s) & ID with this form.

PRIMARY

Primary Insurance Carrier Name

Insured Name | Insured SSN | Insured Birth Date

Address | City/State/ZIP

Phone # | Relationship to Patient

SECONDARY

Secondary Insurance Carrier Name

Insured Name | Insured SSN | Insured Birth Date

Address | City/State/ZIP

Phone # | Relationship to Patient

Authorization to Release Information: I hereby authorize Self Medical Group (SMG) to release information acquired in the course of my medical treatment to my insurance companies. I also authorize payment directly to SMG for medical treatment received and claims submitted on an assigned basis.

I Further Understand and agree that: By signing below, either personally or through the person legally empowered to give consent, I authorize SMG, its employees, agents and other affiliates to provide general care for this and all subsequent requests for care. SMG shall also be entitled to the recovery of all its expenses, including all collection fees, attorney's fees and other legal costs, that it incurs in connection with the collection or recovery of an unpaid balance on my account and that these costs of collection shall be immediately due and payable upon demand.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ❑ YES ❑ NO

IF YES, WHOM? _____

Signature _____ **Date** _____