New Patient Registration Form

SELF REGIONAL HEALTHCARE

Today's Date:________________

Patient Demographics

Legal Last Name ______________________ Legal First Name ________________ Middle Initial ___ Preferred First Name ________________

Social Security# ____________________ Birth Date ________________________ Language____

Perm. Street Address ________________________________ Apt. # _____ City _________________________ State ____ Zip_________

Home Phone _____________________ Cell Phone ____________________ Email ____

Preferred Provider/Primary Care Physician ____

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

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 ______________________ 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 Insurance Carrier Name____

Insured Name ________________________ Insured SSN ___________

Insured Birth Date _____________ Address ________________________

City ______________________________ State ____ Zip ________

Phone # _______________ Relationship to Patient __________________

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 Regional Healthcare (SRH) to release information acquired in the course of my medical treatment to my insurance companies. I also authorize payment directly to SRH 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 SRH, its employees, 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 ________________