

## PATIENT REGISTRATION FORM

Main Campus     Specialty Campus

Expected Admit Date: \_\_\_\_\_  Inpatient/Surgical     Outpatient/Surgical     Maternity Admit     Test/Clinic  
 Diagnosis: \_\_\_\_\_ Date Illness Began: \_\_\_\_\_  
 Admitting Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Patients Name: \_\_\_\_\_ Social Security: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Race: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Religious Preference: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_

Legal Next of Kin/Spouse: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 If policy holder of insurance: Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 If retired, date of retirement: \_\_\_\_\_ Employer: \_\_\_\_\_  
 If next of Kin unavailable contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Emergency: \_\_\_\_\_

**CONTACT YOUR PCP OR INSURANCE COMPANY IF YOU ARE UNSURE ABOUT REFERRAL/AUTHORIZATION REQUIREMENTS**

### Medicaid/Healthy Options

If eligible for Department of Social and Health Services  
 Plan: \_\_\_\_\_  
 Plan/Member #: \_\_\_\_\_  
 Case No.: \_\_\_\_\_  
 PIC #: \_\_\_\_\_  
*Pic # example: JA 070476 SMITH A*

### Primary Insurance

Insurance: \_\_\_\_\_  
 Plan type (HMO/PPO): \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 Ins. Co. Billing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_

### Secondary Insurance

Insurance: \_\_\_\_\_  
 Plan type (HMO/PPO): \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 Ins. Co. Billing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_

### Accident/Injury Claim

Work    Auto    Other

Claim #: \_\_\_\_\_  
 Date of Injury: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Describe how injury occurred:  
 \_\_\_\_\_

### Medicare

Medicare Number: \_\_\_\_\_ Part A  Part B   
 Have you been admitted to a hospital overnight in the last 60 days? Yes  No   
 If yes, provide name of facility and date: \_\_\_\_\_

**Complete Primary Insurance above for Managed Care Medicare Medicare Patients – Please see reverse side for additional questions**

**Please be sure to bring your medical insurance and pharmacy cards at time of service**

**MEDICARE QUESTIONNAIRE – Required for all Medicare Patients**

- Yes  No  Are you receiving Black Lung Benefits?
- Yes  No  Are services to be paid by a Government Program (IE. Research grant)?
- Yes  No  Has the Department of Veterans Affairs authorized care at this facility?
- Yes  No  Is your illness or Injury due to a work-related accident or condition?
- Yes  No  Is your illness or injury due to a non-work related accident or condition?
- Yes  No  Do you receive group medical coverage based on you or your spouse's current employment?

(Note: this does not include retirement benefits that are secondary to Medicare)

- Are you entitled to Medicare based on: Yes  No  Age
- Yes  No  Disability
- Yes  No  End Stage Renal Disease (ESRD)

This sheet is intended for prescreening purposes only. If you have answered yes to any of the above questions or are receiving Medicare benefits due to a Disability or ESRD more information will be required to process your registration.