VIDANT HEALTH™

PATIENT REGISTRATION FORM

Date: _____ (To be completed by staff - MR #_____, Chart #_____)

Last Name: _____First Name: _____ Middle/Maiden_____

Preferred Name:_____ Date of Birth: ____ / ____ / _____ Age: _____ Race:_____

Sex: Male / Female SSN: _____ - _____ - _____ Marital Status: ____Single ____Married ____Divorced ____Widowed

Mailing Address: _____City/State/Zip: _____

Physical Address: _____City/State/Zip: _____

Home Phone #_____ Cell #_____ Work #_____

Ethnic Group: Non-Hispanic / Hispanic / Unknown Preferred/Primary Language:_____

Need Interpreter: Yes / No E-mail Address: _____

Employment Status: Full Time / Part Time / Retired / Self Emp / Disabled / Active Military / Student / Minor / Not Employed

Employer: _____ Occupation:_____

Emergency Contact Name: _____Relationship:_____ Phone#: _____

Primary Care Provider (PCP):_____ PCP Phone #:_____

Who referred you? _____

Do you have an Advance Directive or Living Will: Yes / No If yes, please provide us with a copy.

Do you have a Financial and/or Medical Power of Attorney: Yes / No If yes, please provide us with a copy.

INSURANCE INFORMATION – Please provide your insurance card/cards

Insurance Company Name: _____

Subscriber's Name: _____ Subscriber's Date of Birth _____

Policy #:_____ Group #:_____ Relationship to Patient:_____

Secondary Insurance Company Name: _____

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Policy #_____ Group #_____ Relationship to Patient:_____

PARENT/LEGAL GUARDIAN/SPOUSAL INFORMATION

Name: _____

Relationship to Patient: _____

Date of Birth:_____SSN_____

Address: _____

City/State/Zip: _____

Home #: _____ Cell#:_____

Employer Name: _____

Work #:_____

OTHER INFORMATION

Pharmacy Name: _____

Pharmacy Address:_____

_____

Pharmacy Phone #:_____

Religion:_____

Primary Caregiver:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize payment of all medical benefits which are payable to me under the terms of my insurance policy to be paid directly to the above named physician for services rendered.

_____

Signature of Patient/Guardian Date