Patient Registration

Community General Hospital
More than medicine

Today's Date: _____

Pre-Admission visit #: _____ Maternity/Surgery visit #:_____ **(Internal use only)**

I: PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____ Sex:_____
Last name First name Middle Initial

Address:_____ Marital Status:_____ Race:_____

City: _____ State: _____ Zip: _____ Home Phone #: _____ SS#:_____

Primary Language:_____ Previous/Maiden Name:_____

Veteran Status: _____Veteran _____Not a Veteran _____Spouse of a Veteran Active Duty: YES NO (circle one)

Primary Care MD:_____ Address:_____ Phone:_____

Referred By:_____ Address:_____ Phone:_____

II: EMERGENCY CONTACT/MUST BE A GUARDIAN FOR A PATIENT UNDER THE AGE OF 18:

Name: _____ Relationship:_____

Street Address: _____ Home Phone #: _____ Alt/Wk Phone:_____

City:_____ State:_____ Zip:_____

(SPOUSE OR GUARDIAN ONLY)
Social Sec #:_____ Date of Birth: _____

III: EMPLOYER:

Name:_____ Phone #: _____

Street Address:_____ City:_____ State:_____ Zip:_____

Employment Status: _____FTime _____PTime _____Retired Occupation: _____ Student: _____ Ptime _____ Ftime

IV: INSURANCE INFORMATION: (see reverse side for additional information)

1. PRIMARY INS NAME:_____ Insurance Address:_____

ID #:_____ Insurance Phone #:_____

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

Subscriber's Social Security #_____ Subscriber's Employer:_____

Employment Status: _____FTime _____PTime _____Retired

2. SECONDARY INS NAME:_____ Insurance Address:_____

ID #:_____ Insurance Phone #:_____

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

Subscriber's Social Security #_____ Subscriber's Employer:_____

Employment Status: _____FTime _____PTime _____Retired

**** SEE REVERSE SIDE FOR ADDITIONAL INFORMATION ****

3. MEDICARE PATIENT'S ONLY:

Medicare Claim Number:_____ Subscriber name:_____

Part A effective date: _____ Retirement date (if applicable): _____

Part B effective date: _____ Subscriber's Date of Birth:_____

Subscriber's Employer:_____ Employment Status: _____FTime _____PTime _____Retired

4. WORKER'S COMPENSATION INSURANCE (IF APPLICABLE)

Employer Name at the time of the accident: Carrier Name: _____

_____ Worker's Comp. ID#: _____

Address: _____ Date/time of accident: _____

_____ Claim/Case#: _____

Phone #: _____

5. ARMED FORCES INSURANCE INFORMATION

Sponsor's name: _____ Relationship to patient: _____

Branch and status: _____ Rank: _____

Identification #: _____ Effective date: _____

Expiration date: _____

6. NO-FAULT INSURANCE

Date/time of accident: _____ Carrier Name: _____

Place of accident: _____ Address: _____

Policy #: _____ Phone #: _____

Insured/Policy holder: _____

7. NEWBORN INSURANCE INFORMATION:

Subscriber's Name: _____ Insurance Address:_____

Subscriber's Date of Birth:_____ Insurance Phone #:_____

MEDICAID INFORMATION:

Patient Identification #: _____ Unborn Identification#: _____

County: _____ State: _____