PATIENT REGISTRATION FORM

ABC Health Care * Main Street Hospital * Medical Center

CHART # ____/____/____

PLEASE PRINT ALL INFORMATION

LAST NAME: ______________ First Name: ______________ Middle Init: ____

Maiden Name: ______________ Birthday: ______________

Address: ______________
City State Zip

Telephone Number ______________ Race ________ Religion ________

Social Security # ______________ Sex ☐M ☐F Martial Status ☐S ☐M ☐D ☐W

EMPLOYER: ______________

Address: ______________
City State Zip

Telephone: ______________ Occupation: ______________

PRIMARY INSURANCE ______________ Name of Insured ______________

Policy/Group # ______________ ID # ______________

SECONDARY INSURANCE ______________ Name of Insured ______________

Policy/Group # ______________ ID # ______________

EMERGENCY CONTACT: ______________

Relationship: ______________ Telephone Number: ______________

Address ______________
City State Zip

REASON FOR VISIT: ______________

List any Allergies: ______________

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process all insurance claims.
I permit a copy of this authorization to be used in place of the original.
I here authorize that payment be made directly to Doctor or Hospital providing service.
I understand that if my insurance company does not pay for services, I am responsible for all bills.

Date: ______________ **Signature:** ______________

Sample

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