DATE _____

# PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

## PATIENT INFORMATION

SOCIAL SECURITY # _____ HOME ADDRESS _____

FIRST NAME _____ MIDDLE _____ CITY _____ STATE ___ ZIP _____

LAST NAME _____ EMAIL _____

SEX _____ DATE OF BIRTH ___/___/___ HOME PHONE (___) _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED WORK PHONE (___) _____

(check one) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT CELL PHONE (___) _____

☐ OTHER _____ REFERRING PHYSICIAN _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

## INSURANCE INFORMATION

**PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST**

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____ CO-PAY $ _____

INSURANCE COMPANY _____ EFFECTIVE DATE ___/___/___ EXPIRATION DATE ___/___/___

INSUREDS / CARD HOLDERS NAME _____ RELATIONSHIP _____

POLICY# _____ GROUP# _____ PHONE (___) _____

## COMPLETE IF YOU ARE COVERED UNDER SOMEONE ELSE'S INSURANCE PLAN OR YOU ARE UNINSURED

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH ___/___/___

RELATIONSHIP _____ DAYTIME PHONE (___) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE ___ ZIP _____

CITY _____ STATE ___ ZIP _____

## SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____ CO-PAY $ _____

INSURANCE COMPANY _____ EFFECTIVE DATE ___/___/___ EXPIRATION DATE ___/___/___

INSUREDS / CARD HOLDERS NAME _____ RELATIONSHIP _____

POLICY# _____ GROUP# _____ PHONE (___) _____

## EMERGENCY CONTACT

FIRST NAME _____ MIDDLE _____ HOME PHONE (___) _____

LAST NAME _____ WORK PHONE (___) _____

## WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE (___) _____

SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE (___) _____

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to ST. STEVEN MEDICAL CENTER LTD. for the Surgical and/or Medical Benefits, if any, otherwise payable to me for their services as described, realizing I am responsible to pay for non-covered services.

_____
SIGNATURE (Patient or Parent if Minor) DATE

**ACKNOWLEDGMENT OF FINANCIAL POLICY:** I understand charges over 60 days accrue a finance charge: 1.5% monthly or 18% annually with a minimum charge of $.50

_____
SIGNATURE DATE