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Patient Information: **REGISTRATION FORM** Date: \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dwelling Type:**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pvt. Home Pvt. Apt Detox/PHP

Address2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Rm: \_\_\_\_\_\_\_ IOP/OP Group Home/RES/HH

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_\_\_ Adult community Assisted LF Gpo Ho

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_

Marital Status: M S W D Live with: Spouse Children, \_\_\_\_\_\_\_\_how many Alone

DOB: \_\_\_/\_\_\_/\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed Unemployed Retired

Guarantor Information: Patient is guarantor (financially responsible party)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationships:**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child Spouse Guardian

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_\_\_ Other

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_

Medical Decision Maker: Patient is medical decision maker (need copies of documents, if applicable)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Relation/Position:

Emergency Contact:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ Relation:

Insurance Information:

**Insurance Company Name**:

Address (if not Medicare):

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:

Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: Spouse

Insurance Type: Medicare Traditional HMO PPO Automobile

**Secondary Insurance Company Name**:

Address:

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:

Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: Spouse

Insurance Type: Medicare Traditional HMO PPO

Physician Information:

Previous Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, ST:

Other Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_ City, ST:

Other Specialist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_ City, ST:

Pharmacy Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_ City, ST \_\_\_\_\_\_\_\_\_\_\_

**I attest that the above information is correct to the best of my knowledge.**  Patient Guarantor