

PATIENT REGISTRATION

*All New Patients Effective _____

PATIENT INFORMATION

Last Name _____ First _____ MI _____ Date of Birth ____/____/____ Age _____ Sex _____

Other Name (Maiden/Nickname/AKA) _____ Mother's Name _____ Pt.'s SS# _____ - _____ - _____

Address _____ Apt/Unit# _____

City _____ ST _____ Zip _____ Phone (_____) _____

Marital Status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Race _____

INFECTIOUS DISEASE

Has child had Chicken Pox _____ Been exposed to Chicken Pox, Measles, Mumps or Rubella in the last 3 weeks? _____

Has child/family been exposed to TB (or persistent cough greater than 2 weeks) or any other communicable disease in last 3 weeks? _____

If yes, when/how _____

School _____ School Phone # (_____) _____ Grade _____

PATIENT EMPLOYER/EMERGENCY NOTIFICATION

*** Person to Notify (Other than Parent) ***

Name _____ Address _____

City _____ ST _____ Zip _____ Home Phone (_____) _____

Work Phone (_____) _____ Relationship to Patient _____

Patient's Employer _____

Address _____ City _____ ST _____ Zip _____

Phone (_____) _____ Employment Status _____

LEGAL PARENT/GUARDIANSHIP, GUARANTOR INFORMATION

Legal Parent or Guardian _____ Child lives with _____

SS# _____ - _____ - _____

Address _____ City _____ ST _____ Zip _____

Home Phone (_____) _____ Relationship to Patient _____

Employer _____ Address _____

City _____ St _____ Zip _____ Phone (_____) _____

Occupation _____ Employment Status _____

Parent's Date of Birth ____/____/____ Parent's Drivers License _____

FOR OFFICE USE ONLY

Date of Appointment _____

Today's Date _____

Hospital Authorization Number _____

Physician's Authorization Number _____

Expiration Date of Authorization Number _____

Authorized by: _____

GUARANTOR II INFORMATION

Name _____ SS# _____ - _____ - _____
Address _____ City _____ ST _____ Zip _____
Home Phone (_____) _____ Relationship to Patient _____
Employer _____ Address _____ City _____
ST _____ Zip _____ Phone (_____) _____ Occupation _____ Employment Status _____
Foster Parent _____ Phone (_____) _____

INSURANCE INFORMATION

(Office personnel please attach insurance card)

Insurance Company _____ Phone (_____) _____
Address _____ City _____ ST _____ Zip _____
Subscriber Date of Birth ____/____/____ Social Security Number _____ - _____ - _____
Name of Subscriber _____ Relationship to Patient _____
Policy # _____ Group Name/Number _____

Secondary Insurance (If Applicable)

Insurance Company _____ Phone (_____) _____
Address _____ City _____ ST _____ Zip _____
Subscriber Date of Birth ____/____/____ Social Security Number _____ - _____ - _____
Name of Subscriber _____ Relationship to Patient _____
Policy # _____ Group Name/Number _____

Medicaid Information (If Applicable)

Name of Subscriber _____ Subscriber ID or Gold Card Number _____

Children's Medical Services (If Applicable)

City _____ Nurse _____

Attending Physician _____

Family Physician / Pediatrician _____

Referring Physician _____

Reason for Visit _____

COMMENTS _____

STATEMENT OF TRUTHFULNESS: I state that any and all of the information provided is true and correct. Further, I understand that this form may be shared between All Children's Hospital and Physician practices.

Signature _____