Select One: NEW PATIENT ☐ 24HR RETURN ☐ VISITOR ☐ NO UPDATES/CHANGES ☐

Last Service Date _____

Patient Registration Form

Have you or any household members traveled in the last 12 months? ☐ Yes ☐ No **If YES, from where?** _____

Do you have or had contact with anyone known to have any infectious diseases**?** ☐ Yes ☐ No **If YES, When?**_____
(Tuberculosis-TB, Chicken Pox, Measles, Covid -19, Meningitis, Ebola, Whooping Cough, Flu, etc.)

Please advise if you have any of the following symptoms:

☐ **FEVER / CHILLS**	☐ **RASH**	☐ **NEW LOSS OF TASTE/SMELL**
☐ **COUGH**	☐ **MUSCLE/JOINT PAIN**	☐ **RED EYES or BLEEDING**
☐ **SHORTNESS OF BREATH**	☐ **SORE THROAT**	☐ **NAUSEA / VOMITTING, DIARRHEA**

Name of Patient _____
Last **First** **MI**

Date of Birth: _____ **Sex: ☐ M / ☐ F** Place of Birth: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Telephone (Cell/Mobile): _____-_____-_____ Other: _____-_____-_____ext. _____

Email Address_____ Use Email ☐Yes ☐No

Marital Status: ☐M ☐S ☐W ☐D Social Security #: _____--_____--_____ Race: ☐B ☐W Other: _____

Religion/ Affiliation: _____

Employer Name: _____

Employer Mailing Address: _____ Phone #: _____

Occupation: _____ Employment Status: _____ *(FT/PT, etc.)*

EMERGENCY CONTACT INFORMATION

(1) NEXT OF KIN *(Closest living relative by blood or marriage for legal/medical)*

Name: (First) _____ (Last) _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (Cell/Mobile) _____--_____--_____ (Other) _____--_____--_____ ext. _____

Relationship to Patient: _____

☐ **Same as Next of Kin** *(If checked skip to next section)*

(2) PERSON TO NOTIFY *(Primary contact person for emergency or status updates)*

Name: (First) _____ (Last) _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (Cell/Mobile) _____--_____--_____ (Other) _____--_____--_____ ext. _____

Relationship to Patient: _____

GUARANTOR *(Person responsible for payment)*: _____

☐ **SAME AS PATIENT** *(Not applicable for minor children, Check if the patient is the guarantor and complete the mailing details before skipping to next section)* ☐ **Mailing Address Same as Physical Address** *(If checked skip to next section)*

Mailing Address: _____ City: _____ State: _____ Zip: _____

Telephone (Cell/Mobile): _____-_____-_____

Email Address_____ Social Security #: _____--_____--_____

Relationship to patient: _____

Guarantor Employer Name: _____

Employer Mailing Address: _____ Phone #: _____

Occupation: _____ Employment Status: _____ *(FT/PT, etc.)*

VETERAN STATUS: ☐ Yes ☐ No | Receiving VA Health Benefits? ☐ Yes ☐ No

INSURANCE: Please list all active plans and/or provide all insurance cards to the clerk for registration.

Insurance # 1: _____

Policy Holder Name: _____

SSN: _____-____-_____ DOB: _____

ID /Policy #:_____

Group #: _____

Insurance # 2: _____

Policy Holder Name: _____

SSN: _____-____-_____ DOB: _____

ID /Policy #:_____

Group #: _____

FINANCIAL ALTERNATIVES (Uninsured or Underinsured Patients):

If you currently have limited or no insurance, would you like to receive more info and apply for temporary assistance?

☐ YES, **HPE** *(Temporary Medicaid aka Hospital Presumptive Eligibility)*

☐ Yes, **CHARITY CARE** *(In-House Financial Discounts up to 100% applicable to ALL qualifying patients insured or not)*

☐ **NO / DECLINE** *I decline to apply for assistance and assume full responsibility for the balance as a Self-Pay patient.*

**Patients may be eligible and apply for multiple financial assistance programs if they meet the qualifying criteria*

**Self-pay patients have the right to a Good Faith Estimate of expected charges under the No Surprise Act.*

Do you have any known allergies (Medications, Food, Latex, or Contrast/Dye)? ☐ No ☐ Yes: _____

Are you providing a **Power of Attorney (POA)** today? ☐ **Yes** ☐ **No**

What is your Primary Language? ☐ English ☐ Spanish ☐ Creole ☐ Other: _____

Who is your Primary Care Provider **(Doctor):** _____

ADT Opt-Out: Check here if you **DO NOT** want your primary doctor notified of your admission/discharge**:** ☐

*I certify the details on this form and options selected are correct and acknowledge receipt of patient notices.

Signature: _____ **Print**: _____ **Date:** _____ **Time:** _____

(Patient or Legal Representative)

Affix Patient Label Here