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HSS: \_\_\_\_\_

**PATIENT REGISTRATION FORM**

**PLEASE PRINT CLEARLY. PLEASE PRINT BOTH YOUR LEGAL FIRST AND LAST NAME**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Ethnicity \_\_\_\_\_ Religion \_\_\_\_\_

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Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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**Guarantor** (person responsible for bill if other than patient)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

\*\*\*\*\*SEE REVERSE SIDE\*\*\*\*\*

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**Primary Insurance** (Circle One) Medicare OR Private Insurance

Insurance Company Name\_\_\_\_\_

Insurance Company Address\_\_\_\_\_

City\_\_\_\_\_State\_\_\_\_\_Zip Code\_\_\_\_\_

Insurance Telephone Number(s)\_\_\_\_\_

Policy//ID#\_\_\_\_\_Group#\_\_\_\_\_Claim#\_\_\_\_\_

WCB# (If Workmen's Compensation)\_\_\_\_\_Date of Accident\_\_\_\_\_

Insured's Name\_\_\_\_\_Relationship to Patient\_\_\_\_\_

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**Secondary Insurance** (Circle One) Medicare OR Private Insurance

Insurance Company Name\_\_\_\_\_

Insurance Company Address\_\_\_\_\_

City\_\_\_\_\_State\_\_\_\_\_Zip Code\_\_\_\_\_

Insurance Telephone Number(s)\_\_\_\_\_

Policy//ID#\_\_\_\_\_Group#\_\_\_\_\_Claim#\_\_\_\_\_

WCB# (if Workmen's Compensation)\_\_\_\_\_Date of Accident\_\_\_\_\_

Insured's Name\_\_\_\_\_Relationship to Patient\_\_\_\_\_

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**Person to be Notified in Case of Emergency – Please provide a telephone number other than your own**

Name\_\_\_\_\_Sex\_\_\_\_\_Relationship to Patient\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_State\_\_\_\_\_Zip Code\_\_\_\_\_

Home Phone: (\_\_\_\_\_)\_\_\_\_\_Work Phone:(\_\_\_\_\_)\_\_\_\_\_Cell Phone (\_\_\_\_\_)\_\_\_\_\_

**I certify that the information given above is correct**

**Patient or Guardian's Signature**\_\_\_\_\_ **Date**\_\_\_\_\_