Healthcare South

PATIENT REGISTRATION FORM

Completed by: _____ Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ ☐ Male ☐ Female

Street _____ Apt. No. _____ P.O. Box _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Date of Birth __ __ / __ __ / __ __ __ __

Social Sec. # _____ Referred By _____ PCP _____

Marital Status of Patient _____

IF MINOR (UNDER 18)

Father's Name: Last Name _____ First Name _____ Middle Name _____

Street _____ Apt. No. _____ P.O. Box _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Date of Birth __ __ / __ __ / __ __ __ __

Mother's Name: Last Name _____ First Name _____ Middle Name _____

Street _____ Apt. No. _____ P.O. Box _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Date of Birth __ __ / __ __ / __ __ __ __

Marital Status of Parents _____

Guardian Name: Last Name _____ First Name _____ Middle Name _____

PRIMARY INSURANCE COMPANY INFORMATION

Company Name _____ Group Name or Number _____ Effective Policy Date __ __ / __ __ / __ __ __ __

ID # _____ Co-Pay Amount _____

Subscriber Name: Last Name _____ First Name _____ Middle Initial ____ ☐ Male ☐ Female Date of Birth __ __ / __ __ / __ __ __ __

Street _____ Apt. No. _____ P.O. Box _____

City _____ State _____ Zip Code _____

Insured's Employer _____

SECONDARY INSURANCE COMPANY INFORMATION

Company Name _____ Group Name or Number _____ Effective Policy Date __ __ / __ __ / __ __

ID # _____ Co-Pay Amount _____

Subscriber Name: Last Name _____ First Name _____ Middle Initial ____ ☐ Male ☐ Female Date of Birth __ __ / __ __ / __ __ __ __

Street _____ Apt. No. _____ P.O. Box _____

City _____ State _____ Zip Code _____

Insured's Employer _____

PLEASE COMPLETE REVERSE SIDE

IN CASE OF EMERGENCY CALL

Name:_____ Phone: (___) _____ Relationship _____

Other Information _____

FAMILY MEMBERS

Last Name	First Name	Middle Name	Relationship	Date of Birth

PATIENT MEDICAL HISTORY

Allergies: _____

Medications Taken Regularly: _____

Hospitalizations:

Hospital	Dates	Reason

FAMILY MEDICAL HISTORY

Has anyone in your family had: Cancer, heart disease, diabetes, tuberculosis, allergies, seizures, or other serious medical conditions?

☐ Yes (Please list) ☐ No

_____

_____

_____

OTHER RELEVANT INFORMATION

_____

_____

PAYMENTS OF BENEFITS

I authorize payment of benefits as determined by the Insurance Company directly to:

Surgeon/Physician ☐ Yes ☐ No

I understand that even if I have checked "Yes" above I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.

_____ _____

Signature of Patient or Legal Guardian Date

MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must sign if not minor. I authorize any insurance company, organization, employer, hospital physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ _____

Signature of Patient or Legal Guardian Date

FOR OFFICE USE ONLY

Copy of Insurance Card? ☐ Yes ☐ No Eligibility Checked? ☐ Yes ☐ No