Hendricks Regional Health

NEW PATIENT REGISTRATION

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security #____-____-_____Last Name_____First Name_____Middle_____

Address_____City_____St_____Zip_____

Home Phone (___)____-_____Work Phone (___)__-_____Ext._____Email:_____

Date of Birth_____Marital Status_____Race_____Sex__Alternate Phone (___)_____-_____

Emergency Contact_____Phone (_____)_____-_____
(Name) (Relationship)

Patient Employer_____Emp. Address_____Emp. Phone (___)_____-_____

Pharmacy most used by patient_____Pharm. Phone (____)____-_____

Referring Provider (Specialist office only) _____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____

Social Security #_____-____-_____Name _____

Address_____City_____St_____Zip_____

Home Phone (___)____-_____Work Phone (____)____-_____Ext._____Email:_____

Date of Birth_____Marital Status_____Race_____Sex ___ Alternate Phone (____)_____-_____

Employer_____Emp. Address_____Emp. Phone (___)____-_____

PRIMARY INSURANCE COMPANY NAME_____No Insurance
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name:_____Date of birth_____SS#_-_-_____

Employer_____PCP_____Copay_____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name:_____Date of birth _____ SS#____-___-_____

Employer_____Copay _____
