Piedmont HEALTHCARE

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ **Nickname** _____ **Sex:** ❑ Male ❑ Female

Date of birth _____ **Social security number** _____ **Race** _____ **Preferred language** _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Marital status**: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address:_____
(Street, city, state, zip code, county)

Home phone number:_____ **Cell phone number**:_____ **Work number**:_____

Email:_____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date:_____

Employer name:_____ **Employer phone number**:_____

Employer complete address:_____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ❑ Same as patient

Full legal name (First, Middle, Last, suffix) _____ **Date of birth** _____ **Social security number** _____

Relation to patient: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other:_____ **Sex**: ❑ Male ❑ Female

Home phone number:_____ **Cell phone number**:_____ **Work number**:_____

Complete mailing address – if different from patient:_____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date:_____

Employer name:_____ **Employer phone number**:_____

Employer complete address:_____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last):_____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other:_____

Home phone number:_____ **Cell phone number**:_____ **Work number**:_____

Complete mailing address – if different from patient:_____

INSURANCE INFORMATION ❑ Self-pay (no insurance)

Primary insurance:_____ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____

Secondary insurance:_____ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other:_____

Prescription/Rx provider:_____ **(if different from insurance carrier)**

Full name of subscriber:_____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth:_____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date:_____

Employer name:_____ **Employer size**: ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address:_____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ❑ **Yes or** ❑ **No**

DO NOT SCAN