Regional Health

Patient Registration

Patient Information

Last Name	
First Name, Middle Initial	
Sex	❑ Male ❑ Female
Previous Last Name	
Date of Birth (MM/DD/YYYY)	
Social Security Number	
Address - Physical	
Address - Mailing	
City/State/Zip	
Home Phone	
Work Phone	
Cell Phone	
Email	
Marital Status	❑ Single ❑ Married ❑ Widowed ❑ Partner ❑ Divorced

Language/Race/Ethnicity

Preferred Language	
Race	
Ethnicity	

Guardian Information *(if minor patient)*

Guardian Last Name	
Guardian First Name	
Middle Initial +Suffix	

Emergency Contact

Emergency Contact Name	
Emergency Contact Relation	
Emergency Contact Phone-1	
Emergency Contact Phone-2	

Next of Kin

Next of Kin Name	
Next of Kin Relation	
Next of Kin Phone	

Please present all insurance cards to the registration staff so claims can be filed correctly.

Primary Insured's date of birth_____

No Insurance ❑

Patient Employer

Employer	
Employer Phone	
Occupation	

Guarantor Information

❑ same as patient information

Relationship	
Guarantor Last Name	
Guarantor First Name	
Middle Initial + Suffix	
Date of Birth	
Address	
City/State/Zip	
Social Security Number	
Guarantor Phone	
Guarantor Employer	

May we leave a message on your home phone?
❑ Yes ❑ No

May we leave a message at work?
❑ Yes ❑ No

Preferred number to be contacted at?
❑ Home ❑ Work ❑ Cell

Do you have any cultural and/or religious practices that would affect your health care?
❑ Yes ❑ No

Do you have a Durable Healthcare Power of Attorney or Living Will?
❑ Yes ❑ No

If no, would you like more information?
❑ Yes ❑ No

If yes, do we have a copy?
❑ Yes ❑ No

Which Pharmacy do you use?_____

Location:_____

I give Regional Health permission to share my medical information with the following:

1._____ 2._____

Patient or Surrogate Decision Maker Name PRINTED: _____ Relationship to Patient: _____

Patient or Surrogate Decision Maker Signature: _____ Date: _____ Time: _____