

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 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 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 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