Piedmont HEALTHCARE

Patient Registration

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**

Not a Part of the Legal Medical Record