

**Saint Luke's Medical Group
Patient Registration**

TODAY'S DATE: _____
NAME: _____ SSN: _____ MRN: _____
AKA: _____ SEX: _____ DOB: _____ MARITAL STATUS: _____ COUNTY: _____
ADDRESS: _____ CITY, STATE: _____ ZIP: _____
TELEPHONE #: _____ CELL PHONE #: _____ E-MAIL: _____
PREFERRED LOCAL PHARMACY: _____ STUDENT: _____ FULL/PART TIME? (circle)
EMPLOYER: _____ TELEPHONE #: _____ EXT: _____
EMERGENCY CONTACT: _____ TELEPHONE #: _____

** GUARANTOR INFORMATION **

GUARANTOR NAME: _____ TELEPHONE #: _____
ADDRESS: _____
EMPLOYER NAME: _____ TELEPHONE #: _____
EMPLOYER ADDRESS: _____

** INSURANCE INFORMATION **

*FIELDS MARKED BY AN ASTERISK ARE REQUIRED FIELDS

*PRIMARY INSURANCE: _____
*CERTIFICATE # _____ *GROUP NAME/#: _____ *SUBSCRIBER DOB: _____
*SUBSCRIBER NAME: _____ SUBSCRIBER SSN: _____ *SEX: _____ COPAY: _____
* REL. TO SUBSCRIBER : _____ *SUBSCRIBER EMPLOYER: _____
SECONDARY INSURANCE: _____
*CERTIFICATE: _____ *GROUP NAME #: _____ *SUBSCRIBER DOB: _____
*SUBSCRIBER NAME: _____ SUBSCRIBER SSN: _____ *SEX: _____ COPAY: _____
* REL. TO SUBSCRIBER: _____ *SUBSCRIBER EMPLOYER: _____

MEDICARE PRESCRIPTION CARD INFORMATION

PBM NAME: _____
PBM GROUP #: _____ PBM MEMBER #: _____

** SPECIAL PERMISSIONS **

PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW:	INITIAL	DATE
I GIVE SLMG PERMISSION TO LEAVE VOICE MAIL OR ANSWERING MACHINE MESSAGES AT MY HOME. THE MESSAGE CAN INCLUDE THE NATURE OF THE CALL, BUT NOT SPECIFIC INFORMATION.	_____	_____
I GIVE SLMG PERMISSION TO LEAVE SPECIFIC MEDICAL INFORMATION ON MY VOICE MAIL OR ANSWERING MACHINE AT MY HOME.	_____	_____
I GIVE SLMG PERMISSION TO CALL ME ON MY CELL PHONE.	_____	_____
I GIVE SLMG PERMISSION TO DISCUSS MY MEDICAL CARE/BILLING WITH _____ _____ ANOTHER INDIVIDUAL	_____	_____
I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES.	_____	_____

YOUR PREFERENCE FOR SAINT LUKE'S MAILINGS? (check one)
() NO SLHS MAILINGS PREFERRED () INCLUDE MY NAME ON SLHS CORRESPONDENCE

I HAVE REVIEWED THE ABOVE INFORMATION AND, TO THE BEST OF MY KNOWLEDGE, IT IS CORRECT AND COMPLETE.

(Signature of Patient or Guardian)