Patient Registration Form
(Please Print)

Appointment Date ________/________/________

Patient Information SEX: Male/Female

Last Name: ______________________________ First Name: ______________________________ MI:_________

Nick Name: ________________________ SSN: ________________________

Pt Address: ____ Birth Date: ______________________

City/St/Zip: ______________________________ Hm Phone: ______________________ Cell Phone: ____________________

Martial Status: Single Married Divorced Widowed Pt Language: English Spanish Other_________________

Ethnic Origin: Am Indian Asian Black White Islander Hispanic Multi-Racial Other_________________

Email: ____

Primary Care Physician: ______________________________________ Phone #: ________________________

Referring Physician: ______________________________________ Phone #: ________________________

Patient Employment Info

Pt Employer: ______________________________________Emp Address: ______________________________________

Emp City/St/Zip: ______________________________________Emp Phone: _______________Date of Retirement:_____________

Relative/Emergency Contact

Name:_______________________Address: ____________________________Phone:_____________Relationship:_____________

Insurance Information

Please present your Driver's License and Insurance Cards to the receptionist. If you are unable to provide these, you may be considered a self paying patient.

Primary Insurance:

Plan Name: ____________________________________
Policy #: ____________________________________
Subscriber Name: ______________________________
Group Name/#:___________Subscriber Birth Date: _______

Secondary Insurance:

Plan Name: ____________________________________
Policy #:______________________________________
Subscriber Name: ______________________________
Group Name/#: _____________Subscriber Birth date:_________

SPECIAL PERMISSIONS

PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW: INTIAL DATE

I GIVE 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 PERMISSION TO CALL ME ON MY CELL PHONE. _________ _________

I GIVE PERMISSION TO DISCUSS MY MEDICAL AND DENTAL CARE AND BILLING INFORMATION WITH ______________________________ AND______________________________. _________ _________

I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES. _________ _________

I PREFER TO RECEIVE ST LUKE'S HEALTH SYSTEM INFORMATIONAL MAILINGS:
Circle One Yes No _________ _________

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

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(Signature of Patient or Guardian)