

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: \_\_\_\_\_

Marital 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:**

**Secondary Insurance:**

Plan Name: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Policy #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Group Name/#: \_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_

Group Name/#: \_\_\_\_\_ Subscriber Birth date: \_\_\_\_\_

**\*\*SPECIAL PERMISSIONS\*\***

**PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW:**

INITIAL

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.

\_\_\_\_\_  
(Signature of Patient or Guardian)