HCA Physician Services Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (MI)_____

Also Known As Name (Last)_____(First)_____

Date of Birth _____/_____/_____ ☐ Female ☐ Male Social Security Number _____-_____-_____

Phone Numbers Home_____ Cell _____ Work_____

Mailing Address_____

City, State, ZIP (+4)_____

Physical Address (if different from mailing)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black/African American ☐ White/Caucasian

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language:_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

E-Mail Address_____(used for online surveys only)

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient ☐ Mother ☐ Father ☐ Other:_____

List the names of your child's Parents/Guardians below

Name:_____ Rel:_____ Name:_____ Rel:_____

Name:_____ Rel:_____ Name:_____ Rel:_____

RESPONSIBLE PARTY INFORMATION ***Statements will be addressed to the Responsible Party***

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Also Known As Name (Last)_____(First)_____

Date of Birth _____/_____/_____ ☐ Female ☐ Male Social Security Number _____-_____-_____

Phone Numbers Home_____ Cell_____ Work_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Subscriber_____ Patient Relationship to Subscriber_____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Phone Numbers Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Subscriber_____ Patient Relationship to Subscriber_____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Phone Numbers Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____

Primary Care Physician:_____ **Phone:**_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Patient (or Responsible Party) Signature_____ ***Date***_____