HAC Patient Registration Form

Date_____

PATIENT INFORMATION

Patient Name (Last)_____ (First)_____ (Middle)_____

Address_____ City_____ State_____ Zip_____

911 Address (if different from above) _____

Sex: M/F_____ Birth date_____ Age_____ Social Security #_____

Marital status: (circle one) S M W D Race: (circle one) Asian Black Native American White Other_____

Home Phone_____ Cell Phone _____

Employer_____ Work Phone_____ (Circle one): Full time Part time

Email Address:_____ Referring Physician_____

Emergency contact_____ Relationship to patient _____ Phone No._____

Spouse's Name (if applicable)_____ Spouse's Social Security # _____ Spouse's Birth date _____

Spouse's Employer _____ Work phone _____

Employer Address _____ City, State & Zip _____

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(If patient is less than 18 years of age)

RESPONSIBLE PARTY (Circle one) Father Mother Guardian Other _____

(If different from patient information)

Responsible party's name_____ Responsible party SS#_____ Sex: M/F_____

Address_____ City, State & ZIP_____

911 Address (if different from above) _____

Responsible party Birth date_____ Responsible Party Employer_____

Employer Address _____ City, State & Zip _____

OTHER PARENT/GUARDIAN INFORMATION

Name_____

Address_____ City, State & ZIP_____

Relationship to Patient _____ Employer_____

Employer Address _____ City, State & Zip _____

SS#_____ Birth date_____ Sex: M/F_____

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PRIMARY INSURANCE

Name of Insurance Company_____ Policy Holder_____

Pt. Relation to Policyholder_____ ID#_____ Group#_____

Ins. Phone No._____ Policyholder's Birth date_____ Sex: M/F_____

SECONDARY INSURANCE

Name of Insurance Company_____ Policy Holder_____

Pt. Relation to Policyholder_____ ID#_____ Group#_____

Ins. Phone No._____ Policyholder's Birth date_____ Sex: M/F_____