CHI St. Luke's Health

REGISTRATION FORM - (PLEASE PRINT)

Date:	**PCP's** last name:	First:	Middle:	PCP Ph:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Religion Preference:

Email:	Language:	Interpreter Needed: ❑ Yes ❑ No

Street address: Apt #	Social Security:	Home ph: ( ) Cell ph: ( ) Work ph: ( ) To which # do you wish to receive appointment reminders?

P.O. Box:	City:	State:	ZIP Code:

Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other:	Employer:	Employer ph: ( )

Pharmacy's Name	Pharmacy's Ph: ( )

How did you hear about us:

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )

Occupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE

Name of primary insurance:_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy#:_____

Co-payment: $ _____

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of secondary insurance :_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy #:_____

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Patient/Guardian signature *Date*