Southwest Perinatal Associates

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PATIENT REGISTRATION FORM

TODAY'S DATE _______ /_______ / _______

PATIENT INFORMATION

❑ MR ❑ MRS ❑ MISS ❑ MS MARITAL STATUS (CHECK ONE) ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ SEP ❑ WIDOW SEX ❑ M ❑ F ❑ T

PATIENT NAME ______________________________ DATE OF BIRTH _______ /_______ / _______
LAST FIRST MI

IS THIS YOUR LEGAL NAME? ❑ YES ❑ NO IF NOT, WHAT IS YOUR LEGAL NAME? ______________________________ AGE ________

ADDRESS ______________________________
❑ STREET OR ❑ MAILING (CHECK ONE) CITY STATE ZIP

PHONE (H) ______________ (C) ______________ E-MAIL ADDRESS ______________ SOCIAL SECURITY ______________

OCCUPATION ______________ EMPLOYER ______________ EMPLOYER PHONE # ______________

EMPLOYMENT STATUS ❑ 1 – FULL-TIME ❑ 2 – PART-TIME ❑ 3 – NOT EMPLOYED ❑ 4 – SELF-EMPLOYED ❑ 5 – RETIRED ❑ 6 – ACTIVE MILITARY

STUDENT STATUS ❑ F – FULL-TIME STUDENT ❑ P – PART-TIME STUDENT ❑ N – NOT A STUDENT

RACE ❑ AMERICAN INDIAN/ALASKA NATIVE ❑ ASIAN ❑ NATIVE HAWAIIAN/PACIFIC ISLANDER ❑ BLACK/AFRICAN AMERICAN
❑ WHITE ❑ HISPANIC ❑OTHER ❑ DECLINED

ETHNICITY ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑DECLINED

LANGUAGE ❑ ENGLISH ❑ SPANISH ❑ INDIAN ❑ JAPANESE ❑ CHINESE ❑ KOREAN ❑ FRENCH ❑ GERMAN ❑ RUSSIAN ❑ OTHER ______________

PHARMACY ______________________________ DO YOU HAVE A LIVING WILL? ❑ YES ❑ NO

REFERRED BY (PLEASE CHECK ONE BOX)

❑ DR. ______________ ❑ INSURANCE ❑ HOSPITAL ❑ FAMILY ❑ FRIEND ❑ YELLOW PAGES ❑ OTHER ______________

OTHER FAMILY MEMBERS SEEN HERE ______________________________

PCP NAME ______________________________ PHONE # ______________

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY: ❑ ANOTHER PATIENT ❑ GUARANTOR ❑ SELF ❑ CHECK HERE IF INFORMATION IS SAME AS PATIENT

NAME ______________ ADDRESS ______________ HOME PHONE # ______________

DATE OF BIRTH ______________ E-MAIL ADDRESS ______________ OCCUPATION ______________

EMPLOYER ______________ EMPLOYER ADDRESS ______________ EMPLOYER PHONE # ______________

INSURANCE INFORMATION

IS THIS VISIT FOR ONE OF THE FOLLOWING?
❑ WORKERS COMPENSATION (WC) ❑ OCCUPATIONAL MEDICINE (OM) ❑ MOTOR VEHICLE ACCIDENT (MVA) ❑ ACCIDENT DATE ______________

DOES THE PATIENT HAVE HEALTHCARE COVERAGE? ❑ YES ❑ NO INSURANCE NAME ______________

NAME OF INSURED ______________ SOCIAL SECURITY # ______________ DATE OF BIRTH ______________

EFFECTIVE DATE ______________ GROUP ID ______________ SUBSCRIBER ID (POLICY #) ______________

PATIENT RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ______________

NAME OF SECONDARY INSURANCE ______________ NAME OF INSURED ______________ DATE OF BIRTH ______________

GROUP ID ______________ SUBSCRIBER ID (POLICY #) ______________

PATIENT RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ______________

EMERGENCY CONTACT

NAME ______________________________ RELATIONSHIP TO PATIENT ______________
LAST FIRST

HOME PHONE # ______________ OTHER PHONE # ______________

I AGREE THAT THE INFORMATION SUPPLIED ON THIS FORM IS ACCURATE AND UP-TO-DATE TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE ______________