



Patient Registration Form

Please Print Clearly

Patient # _____ Date: _____

PATIENT INFORMATION:

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

Male Female DOB: _____ SSN: _____ Marital Status: _____

Address: _____ City, State, Zip: _____ County: _____

Home Phone: (____) _____ Alt Phone: (____) _____ Referring Doctor: _____

Employment: Full Time Part Time Self Employed Not Employed Retired/ Retire Date: _____

RESPONSIBLE PARTY: (IF OTHER THAN PATIENT AND/ OR IF PATIENT IS A MINOR, HE/ SHE WILL BE RESPONSIBLE FOR BILL

PAYMENT.) (If address is the same as patient, write SAME)

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (____) _____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE:

Carrier Name: _____ ID: _____ Group #: _____

Subscriber Name: (Last) _____ (First) _____ (MI) _____

Male Female DOB: _____ SSN: _____ Relationship to Patient _____

Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE:

Carrier Name: _____ ID: _____ Group #: _____

Subscriber Name: (Last) _____ (First) _____ (MI) _____

Male Female DOB: _____ SSN: _____ Relationship to Patient _____

Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

I assign all insurance payments to OCH Huxford Clinic. I understand that any unpaid portion of charges for treatment not paid by my insurance company is my responsibility. I understand that if my balance is not paid in a timely manner and the account is referred for outside collections, I am responsible for any processing fees and/or court costs.

Signature: _____ Date: _____

EMERGENCY CONTACT: (please provide a phone # different from your own)

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (____) _____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

Preferred Pharmacy: _____ Address: _____ City, State, Zip: _____

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REVISION HISTORY

| Author | Revision Date | Page # | Summary of Changes |
|--------------|---------------|--------|--------------------|
| Cheryl Smith | 02/25/20 | 1 | creation |
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