PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME: FIRST	MIDDLE	LAST	SEX	S WID. M DIV.	BIRTH DATE
ADDRESS: NUMBER AND STREET					SOCIAL SECURITY NO.
CITY	STATE	ZIP			
HOME PHONE	WORK PHONE	MESSAGE PHONE			IS PATIENT A U.S. CITIZENS? ☐ YES ☐ NO
EMPLOYER: NAME OF FIRM		OCCUPATION			
EMPLOYER ADDRESS:					
REFERRED BY:		**PRIOR/MAIDEN NAME**			

ACCOUNT (HEAD OF HOUSEHOLD) INFORMATION

ACCOUNT NO.

PATIENT NAME: FIRST	MIDDLE	LAST	BIRTH DATE
ADDRESS: NUMBER AND STREET			SOCIAL SECURITY NO.
CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	MESSAGE PHONE	RELATIONSHIP TO PATIENT
EMPLOYER: NAME OF FIRM		EMPLOYER ADDRESS	
SPOUSE NAME NAME: FIRST	MIDDLE	LAST	BIRTH DATE
EMPLOYED BY:		BUSINESS PHONE	

MEDICAL INSURANCE INFORMATION

INS. TYPE

PRIMARY INS.	INS. COMPANY NAME	ADDRESS	CITY	STATE
ADDRESS: NUMBER AND STREET				SOCIAL SECURITY NO.
SUBSCRIBER'S NAME		NAME OF EMPLOYER *IF GROUP COVERAGE)		
EFFECTIVE DATE	GROUP #	IDENTIFICATION #		
OTHER INS.	INS. COMPANY	GROUP & I.D. NO.		
WORKMAN COMP - DATE OF INJURY	CLAIM #	EMPLOYER		

PERSON TO CONTACT IF UNABLE TO REACH YOU DIRECTLY

NAME OF FRIEND OR RELATIVE (NOT LIVING WITH YOU)

NAME: FIRST	MIDDLE	LAST	RELATIONSHIP
ADDRESS: NUMBER AND STREET	CITY	STATE ZIP	PHONE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services. ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits to be made directly to Alsea Rural Health Care for services provided to me by Alsea Rural Health Care I understand that I am financially responsible for charges not covered by insurance. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

Signature of Patient - If minor, then signature of responsible person DATE: