PATIENT REGISTRATION

***All New Patients Effective________________________________**

PATIENT INFORMATION

Last Name_________________________ First_____________________ MI_______ Date of Birth_____/_____/_____ Age________ Sex________

Other Name (Maiden/Nickname/AKA) ___________________________ Mother's Name_______________________ Pt.'s SS# _______-_____-_______

Address____ Apt/Unit#_______________________________________

City____ ST_______ Zip________________ Phone (________) ______________

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed Race________________________

INFECTIOUS DISEASE

Has child had Chicken Pox _____ Been exposed to Chicken Pox, Measles, Mumps or Rubella in the last 3 weeks?_____________________________

Has child/family been exposed to TB (or persistent cough greater than 2 weeks) or any other communicable disease in last 3 weeks? __________________

If yes, when/how____

School____ School Phone # (_______) __________________ Grade ______

PATIENT EMPLOYER/EMERGENCY NOTIFICATION

*** Person to Notify (Other than Parent) ***

Name____ Address____

City ____ ST________ Zip_____________ Home Phone (________) _________________

Work Phone (________) ________________________ Relationship to Patient ____

Patient's Employer____

Address ____ City_________________________ ST________ Zip____________________

Phone (________) _________________________ Employment Status____

LEGAL PARENT/GUARDIANSHIP, GUARANTOR INFORMATION

Legal Parent or Guardian ____ Child lives with _____________________________________

SS# ____________-________-____________

Address____ City____________________________ ST_______ Zip_________________________

Home Phone (________) _____________________________ Relationship to Patient____

Employer____ Address____

City____ St________ Zip__________________ Phone (________) _________________

Occupation____ Employment Status____

Parent's Date of Birth ____________/___________/____________ Parent's Drivers License____

____ **FOR OFFICE USE ONLY** ____

Date of Appointment__________________________________

Today's Date____

Hospital Authorization Number __________________________

Physician's Authorization Number_________________________

Expiration Date of Authorization Number __________________

Authorized by: ______________________________________

ACH# 990403 REV. 11-08

GUARANTOR II INFORMATION

Name_______________________________SS# ________-________-________

Address_______________________ City_____________________ ST ________ Zip ______________

Home Phone (________) ________________ Relationship to Patient_________________________

Employer_______________________ Address___________________ City________________

ST______ Zip __________ Phone (________) ___________ Occupation ______________ Employment Status ________

Foster Parent _____________________________________ Phone (________) __________________

INSURANCE INFORMATION
(Office personnel please attach insurance card)

Insurance Company_________________________________Phone (________) ___________________

Address _________________________ City_____________________ ST______ Zip ______________

Subscriber Date of Birth ________/________/________ Social Security Number ___________-__________-___________

Name of Subscriber___________________________ Relationship to Patient ______________________

Policy # _______________________________ Group Name/Number ___________________________

*****Secondary Insurance (If Applicable)*****

Insurance Company_________________________________Phone (________) ___________________

Address _________________________ City_____________________ ST______ Zip ______________

Subscriber Date of Birth ________/________/________ Social Security Number ___________-__________-___________

Name of Subscriber___________________________ Relationship to Patient ______________________

Policy # _______________________________ Group Name/Number ___________________________

Medicaid Information (If Applicable)

Name of Subscriber___________________________ Subscriber ID or Gold Card Number ________________

Children's Medical Services (If Applicable)

City_____________________________ Nurse__________________________________

Attending Physician ____

Family Physician / Pediatrician _____________________________________

Referring Physician ____

Reason for Visit ____

COMMENTS ____

STATEMENT OF TRUTHFULNESS: I state that any and all of the information provided is true and correct. Further, I understand that this form may be shared between All Children's Hospital and Physician practices.

Signature ______________________________________