SSMHealth

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN

MAIDEN NAME	NAME YOU GO BY	MARITAL STATUS
		☐ S ☐ M ☐ D ☐ W

STREET ADDRESS	APT. NO.

CITY	STATE	ZIP	HOME PHONE

SOCIAL SECURITY NUMBER	AGE	GENDER	CELL PHONE
		☐ Male ☐ Female	

EMPLOYER	OCCUPATION	WORK PHONE

EMERGENCY CONTACT (NOT LIVING WITH YOU) / RELATION TO PATIENT	EMERGENCY CONTACT PHONE

SPOUSE INFORMATION OR PARENT / RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
			☐ Spouse ☐ Parent ☐ Legal guardian ☐ Other _____

STREET ADDRESS	APT. NO.	HOME PHONE

CITY	STATE	ZIP	CELL PHONE

SOCIAL SECURITY NO.	DATE OF BIRTH

RESPONSIBLE PARTY EMPLOYER	OCCUPATION	RESPONSIBLE PARTY WORK PHONE/EXT.

SECOND PARENT INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
			☐ Parent ☐ Legal guardian ☐ Other _____

STREET ADDRESS	APT. NO.	HOME PHONE

CITY	STATE	ZIP	CELL PHONE

SOCIAL SECURITY NO.	DATE OF BIRTH

RESPONSIBLE PARTY EMPLOYER	OCCUPATION	RESPONSIBLE PARTY WORK PHONE/EXT.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE

ID (POLICY NO.)	GROUP NO.	

SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S SOCIAL SECURITY NO.

SECONDARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE

ID (POLICY NO.)	GROUP NO.	

SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S SOCIAL SECURITY NO.

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to the SSM Health Medical Group and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

Authorized signature _____ ***Date*** _____

PLEASE BRING THIS FORM ALONG WITH YOUR INSURANCE CARD(S) AND APPLICABLE COPAY(S) TO YOUR APPOINTMENT. THANK YOU!