PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print)

Last Name:	First Name:	Initial	Date of Birth:
Address:		City:	State: / Zip:
Home Phone:	Cell Phone:	Work Phone:	SSN: / Gender: ❑ M ❑ F
E-Mail Address:		❑ No e-mail address ❑ Prefer not to share e-mail address	Preferred method of contact: ❑ Home ❑ Cell ❑ Work ❑ E-mail

Race: ❑ Asian	❑ Black/African American	❑ White	❑ American Indian	❑ Pacific Islander	❑ Multi-racial	❑ Hispanic or Latino	❑ Prefer not to answer
Ethnicity: (Ethnicity is your ancestral or culture background)		❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑ Unknown	❑ Other		

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Occupation:
Preferred Language:	
Primary Care Doctor:	Preferred Pharmacy:

RESPONSIBLE PARTY INFORMATION

Last Name:	First Name:	Initial	Date of Birth:
Address:		City:	State: / Zip:
Home Phone:	Cell Phone:	Work Phone:	SSN: / Gender: ❑ M ❑ F
Occupation:		Relationship:	

INSURANCE INFORMATION

Primary Insurance:		
Policy Holder:	Insured's Date of Birth:	Insured's SSN:
Insured Employer's Name:	Policy #:	Group #:
Secondary Insurance:		
Policy Holder:	Insured's Date of Birth:	Insured's SSN:
Insured Employer's Name:	Policy #:	Group #:
If you are over 65 years old and Medicare is your SECONDARY policy, please list reason:		

WORKER'S COMPENSATION INFORMATION

Is this visit related to a worker's compensation injury? ❑ No ❑ Yes		If so, Name of Employer:	
Name of Supervisor:	Supervisor Phone:	Name of Case Worker:	Case Worker Phone:
Case #:	Date of Injury:	Name and Address of Company Responsible for Bill:	

EMERGENCY CONTACT INFORMATION

First Contact Name:	Phone:	Relationship:
Second Contact Name:	Phone:	Relationship:

CONSENT TO TREAT

I give permission for Hendrick Provider Network (HPN) to render to me (and/or my named dependent above) medical treatment. I also understand I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Hendrick Provider Network for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine the benefits payable for related and/or provided services. I understand that I must pay my share of the costs, including co-pays and deductibles at each visit. Furthermore, if my insurance does not pay or I do not have insurance, I must pay for the cost of these services.

____________________ Patient Signature for Consent to Treat and Assignment of Benefits	____________________ Signature of Patient Representative (if patient unable to sign)	
____________________ Date Signed	Relationship to Patient:	Reason Patient Unable to Sign: