Clear Form Print Form

LOURDES Primary Care Center

Patient Registration Form

Site:

Patient Information

Name_____ ☐ M ☐ F

DOB_____ Race_____

Address_____

City_____ State_____ Zip_____

SS#_____

Phone (h)_____ (c)_____

What is your primary language?_____

e-mail_____

Provider_____

Marital Status (√ one)

☐ Married ☐ Single ☐ Widow(er)
☐ Divorced ☐ Legally separated
☐ Other_____

Retired ☐ Yes ☐ No **If yes,** Date_____

Patient's Employer

Employer_____

Phone (w)_____ ext_____

Primary Insurance Information

Primary Insurance_____

Policy #_____ Group #_____

Insured Name_____

Insured DOB_____ SS#_____

Relationship of Insured to Patient:

☐ Self ☐ Spouse ☐ Parent

Secondary Insurance Information

Secondary Insurance_____

Policy #_____ Group #_____

Insured Name_____

Insured DOB_____ SS#_____

Relationship - Insured to Patient:

☐ Self ☐ Spouse ☐ Parent

If Patient is a Minor

Minor patients (under 18 years of age) must be accompanied by a parent or guardian, or anyone designated on the Authorization Form filled out by the responsible party.

Legal Guardian_____

DOB_____ Race_____

Address_____

Same as Patient? ☐ Yes

City_____ State_____ Zip_____

SS#_____

Relationship to patient:

☐ Mother ☐ Father ☐ Guardian

Employer_____

Phone (w)_____ ext_____

Emergency Contact

Name:_____

Address_____

Same as Patient? ☐ Yes

City_____ State_____ Zip_____

Employer_____

Phone (w)_____ ext_____

Mobile (c)_____

Patient / Authorized Representative:

_____

Signature:

☐ Patient ☐ Authorized representative, state relationship:_____

Date:_____ Time:_____

☐ **Interpreter Services Used:**

_____

Interpreter # Name Language

Re-Order # Net 030 9/7/16 (PB001, 2 hole)