



PRESBYTERIAN MEDICAL CAMPUS REGISTRATION FORM

DATE: _____

*****PATIENT INFORMATION*****

NAME: Last		First	M.I.	SOCIAL SECURITY #		SEX	MARITAL STATUS		AGE	DATE OF BIRTH
						M F	S M D W			
STREET ADDRESS			CITY	STATE	ZIP	HOME PHONE		BUSINESS PHONE	DRIVER'S LICENSE #	
OCCUPATION		EMPLOYER OR RETIRED FROM		EMPLOYMENT STATUS		EMERGENCY NOTIFICATION OUTSIDE YOUR HOME				
				Full-Time Self-Employed Retired		Part-Time Military Unemployed		Name	Phone	
SPOUSE OR NEXT OF KIN Name		Address		Phone		Relationship		If spouse, is (s)he employed?		
								Y N		

*****MEDICAL INFORMATION*****

REASON FOR THIS VISIT			ACCIDENT?	Date accident occurred		Is accident work related?	
			Y N			Y N	
REFERRED BY		WHO IS YOUR PRIMARY CARE PHYSICIAN?		Address			Phone
		Name					

*****INSURANCE INFORMATION*****

MEDICARE/MEDICAID? Y N		GROUP/INDIVIDUAL INSURANCE COMPANY NAME		Plan Number	Group Number	PPO/HMO?	
						Y N	
INSURED'S NAME		SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	EMPLOYER		EMPLOYMENT STATUS	
						Full-Time Self-Employed Retired	
						Part-Time Military Unemployed	
MAIL CLAIM FORM TO: Address				Phone		Contact Person	

DOES THIS INSURER REQUIRE PREAUTHORIZATION? Y N SECOND SURGICAL OPINION? Y N

OTHER GROUP/INDIVIDUAL INSURANCE COMPANY NAME				Plan Number	Group Number	PPO/HMO?	
						Y N	
INSURED'S NAME		SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	EMPLOYER		EMPLOYMENT STATUS	
						Full-Time Self-Employed Retired	
						Part-Time Military Unemployed	
MAIL CLAIM FORM TO: Address				Phone		Contact Person	

DOES THIS INSURER REQUIRE PREAUTHORIZATION? Y N SECOND SURGICAL OPINION? Y N

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I may revoke this consent at anytime, except where information has already been released. This consent is valid until revoked by me in writing.

Signature

Date