

E.A. HAWSE HEALTH CENTER REGISTRATION FORM

Medical

(Please Print)

Today's Date:	NEW:	UPDATED:
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PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
Email: _____						
Is this your legal name: <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing address:		Social Security No:		Home phone no: ()	Work phone no: ()	Cell phone no: ()
Physical Address:	City:	State:	Zip Code:			
Occupation:	Employer:		Employer phone no: ()			
Race: White <input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/>			Referred by: Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pg <input type="checkbox"/> Other <input type="checkbox"/>			
Ethnic Origin Hispanic or Latino <input type="checkbox"/> Not of Hispanic or Latino Origin <input type="checkbox"/> Declined <input type="checkbox"/>			Military Status: Served in Military <input type="checkbox"/> Did not serve in Military <input type="checkbox"/>			
Language: English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/>			Migrant or Seasonal worker: Yes <input type="checkbox"/> No <input type="checkbox"/>			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth Date:	Group no:	ID no:	Co-Payment: \$
Subscriber's Address:				Home Phone: ()	
Occupation:	Employer:	Employer address:		Employer phone no.: ()	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of Secondary insurance (if applicable):		Subscribers name:		Group no:	ID no:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)	Relationship to patient:	Home phone no: ()	Work phone no: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize E. A. Hawse Health Center or insurance company to release any information required to process my claims. I authorize E. A. Hawse Health Center to perform any necessary treatments of diagnostic tests for Medical or Dental services.

Patient/Guardian Signature

Date