Piedmont HEALTHCARE

PATIENT REGISTRATION FORM

Affix Label

PATIENT INFORMATION

_____ _____ **Sex:** ☐Male ☐Female
Full Legal Name (First, Middle, Last, Suffix) **Nickname:**

_____ _____ _____ _____
Date of Birth **Social Security Number** **Race** **Preferred Language**

Ethnicity: ☐Hispanic ☐Non-Hispanic **Marital Status:** ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Life Partner

_____
Complete Mailing Address (Street, City, State, Zip Code, County)

Home Phone Number: _____ **Cell Phone Number:** _____ **Work Number:** _____

Email: _____

Employment Status: ☐Full-time ☐Part-time ☐Active Duty ☐Self-employed ☐Not employed ☐Retirement Date: _____

Employer Name: _____ **Employer Phone Number:** _____

_____
Employer Complete Address (Street Address, City, State, Zip Code)

SPOUSE OR GUARANTOR INFORMATION (Responsible Party) ☐ Same as Patient

_____ _____ _____
Full Legal Name (First, Middle, Last, Suffix) **Date of Birth** **Social Security Number**

Relation to Patient: ☐ Self ☐ Spouse ☐Mother ☐Father ☐Legal Guardian ☐Other: _____ **Sex:** ☐Male ☐Female

Home Phone Number: _____ **Cell Phone Number:**_____ **Work Number:** _____

_____
Complete Mailing Address – If Different From Patient (Street, City, State, Zip Code, County)

Employment Status: ☐Full-time ☐Part-time ☐Active Duty ☐Self-employed ☐Not employed ☐Retirement Date: _____

Employer Name: _____ **Employer Phone Number:** _____

_____
Employer Complete Address (Street Address, City, State, Zip Code)

EMERGENCY CONTACT INFORMATION

Name (First, Last):_____

Relation to Patient:☐ Spouse ☐Mother ☐Father ☐Legal Guardian ☐Other: _____

Home Phone Number: _____ **Cell Phone Number:**_____ **Work Number:** _____

_____
Complete Mailing Address – If Different From Patient

INSURANCE INFORMATION ☐**Self-pay (no insurance)**

Primary Insurance: _____ **Patient relation to subscriber:** ☐Self ☐Spouse ☐Child ☐Other: _____

Secondary Insurance: _____ **Patient relation to subscriber:** ☐Self ☐Spouse ☐Child ☐Other: _____

Prescription/Rx Provider: _____ **(if different from insurance carrier)**

Full Name of subscriber: _____ **(complete below if different from patient, spouse, or guarantor)**

Employment Status: ☐Full-time ☐Part-time ☐Active Duty ☐Self-employed ☐Not employed ☐Retirement Date: _____

Employer Name: _____ **Employer Size:** ☐ 0-19 employees ☐ 20-99 ☐ 100+

_____
Employer Complete Address (Street Address, City, State, Zip Code)

Primary Care Physician:	**Do you want anyone to know you are here?** ☐**Yes or** ☐ **No**