



VIDANT HEALTH

PATIENT REGISTRATION FORM

Date: (To be completed by staff - MR #, Chart #)

Last Name: First Name: Middle/Maiden

Preferred Name: Date of Birth: Age: Race:

Sex: Male / Female SSN: Marital Status: Single Married Divorced Widowed

Mailing Address: City/State/Zip:

Physical Address: City/State/Zip:

Home Phone # Cell # Work #

Ethnic Group: Non-Hispanic / Hispanic / Unknown Preferred/Primary Language:

Need Interpreter: Yes / No E-mail Address:

Employment Status: Full Time / Part Time / Retired / Self Emp / Disabled / Active Military / Student / Minor / Not Employed

Employer: Occupation:

Emergency Contact Name: Relationship: Phone#:

Primary Care Provider (PCP): PCP Phone #:

Who referred you?

Do you have an Advance Directive or Living Will: Yes / No If yes, please provide us with a copy.

Do you have a Financial and/or Medical Power of Attorney: Yes / No If yes, please provide us with a copy.

INSURANCE INFORMATION - Please provide your insurance card/cards

Insurance Company Name:

Subscriber's Name: Subscriber's Date of Birth

Policy #: Group #: Relationship to Patient:

Secondary Insurance Company Name:

Subscriber's Name: Subscriber's Date of Birth:

Policy # Group # Relationship to Patient:

PARENT/LEGAL GUARDIAN/SPOUSAL INFORMATION OTHER INFORMATION

Name: Pharmacy Name:

Relationship to Patient: Pharmacy Address:

Date of Birth: SSN

Address: Pharmacy Phone #:

City/State/Zip: Religion:

Home #: Cell#: Primary Caregiver:

Employer Name:

Work #:

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 payment of all medical benefits which are payable to me under the terms of my insurance policy to be paid directly to the above named physician for services rendered.

Signature of Patient/Guardian Date