MOUNT CARMEL
Medical Group

# PATIENT REGISTRATION FORM (ADULT)

**OFFICE USE ONLY**
NG Account # _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Name *(first)* _____ *(middle)* _____ *(last)* _____ ❑ male ❑ female

Address _____ Apt# _____

City _____ State _____ Zip _____

Birth Date_____ Age _____ Social Security # _____-_____-_____

Home Phone _____ Work Phone _____

E-Mail _____ Cellular Phone_____

Employed: ❑ yes ❑ no Employer Name _____

Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed

| | | |
|---|---|---|
| May we leave messages at home with other residents | ❑ yes | ❑ no |
| May we leave personal health information on your answering machine/voicemail | ❑ yes* | ❑ no |
| May we contact you via e-mail or cellular telephone | ❑ yes** | ❑ no |
| May we contact you via text message | ❑ yes** | ❑ no |

** Appointment reminders will be left on voicemail.*
***We cannot ensure the confidentiality of information shared by these means.*

Who may we contact in case of Emergency? Name _____

Relationship _____ Phone #1 _____ #2 _____

Please list below all individuals with whom we may talk to about your medical concerns:

***Please Note:*** *We will not release any personal health information to anyone unless they are listed below*

Name_____Relationship_____

Name_____Relationship_____

Name _____ Relationship_____

## INSURANCE INFORMATION

***Note:*** *We require that your card be presented at every visit ~ OR~ if card is not available you must verify eligibility, and provide ID#, group #, mailing address & provider services #. If not, you will be responsible for the cost of the office visit.*

Primary Insurance Company_____ Co-payment $_____

Card Holder Name _____ Birth Date _____

Address _____Social Security # _____-_____-_____

Is insurance through employer: ❑ yes ❑ no If yes, employer _____

Relationship to card holder: ❑ self ❑ mother ❑ father ❑ other

Secondary Insurance _____

Card Holder Name _____ Birth Date _____

Address _____Social Security # _____-_____-_____

Relationship to Card Holder: ❑ self ❑ mother ❑ father ❑ other

Card(s) Copied: Primary: ❑ yes ❑ no Secondary: ❑ yes ❑ no

*I understand that when I sign this document that I am confirming that all information completed by me is correct, I authorize contact in the means identified above and that any falsification can lead to my dismissal from this practice.*

Signature _____ Today's Date _____

**HOW DID YOU HEAR ABOUT US?**

❑ 411 ❑ HealthCALL ❑ Newspaper ❑ Referring Physician_____
❑ Brochure ❑ Insurance Listing ❑ Radio ❑ Other _____
❑ Drive-By Signage ❑ Phone Book ❑ Shopping Cart
❑ Family or Friends ❑ Postcard ❑ Website

Primary Care Physician _____