MRN: _____

Date: _____

St.JosephHealth Medical Group

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Date of Birth: _____ Sex: _____ Driver's Lic #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Last 4 digits of Social Security #: _____ Ethnicity: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Send Appointment Reminders via: ☐ Text ☐ Call Phone # _____

Preferred Telephone # for Routine Communication: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

E-mail: _____ Primary Spoken Language: _____

Primary Care Provider: _____ How were you referred?: _____

Employer: _____ Employer Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

If patient is a child, please provide an emergency contact other than a parent/guardian.

Contact Name: _____ Relation to Patient: _____

Address (Street or P.O.B.) _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone:(____) _____ Cell Phone:(____) _____

PRIMARY RESPONSIBLE PARTY

☐ I am responsible party ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Name: _____
Last First Middle

Date of Birth: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Driver's Lic #: _____

Employer: _____ Employer Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

SECONDARY RESPONSIBLE PARTY

Name: _____ ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Employer: _____ Employer Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

St.JosephHealth Medical Group

MRN:_____

INSURANCE INFORMATION

Primary Insurance Company Name _____

Subscriber's Name _____Date of Birth___/___/_____

Relation to patient_____

Subscriber's address if other than patient _____

Secondary Insurance Company Name _____

Subscriber's Name _____Date of Birth___/___/_____

Relation to patient_____

Subscriber's address if other than patient:_____

ELIGIBILITY GUARANTEE

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I also certify that I have chosen a St. Joseph Heritage Healthcare affiliated medical group to provide healthcare services. I understand that if the above is not true or I am not eligible under the terms of my medical and hospital subscriber agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature_____ Date ____/____/____

COMMUNICATION CONSENT

By providing the St. Joseph Heritage Healthcare or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that St. Joseph Heritage Healthcare or its service providers may use the provided telephone number or e-mail to service my account(s) (including contacting me about obtaining potential financial assistance for my account(s)), to send the patient appointment and follow-up health care reminders by text or e-mail, to send me information, to schedule patient appointments, and to collect any amounts I may owe to my healthcare provider(s). I understand and agree that St. Joseph Heritage Healthcare and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in charges to me. I expressly consent that methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with my account number(s) and is not a condition of purchasing property, goods, or services. I am not required to sign this consent as a condition of receiving healthcare services .

☐ Initials / Approve ☐ Initials / Decline

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to St. Joseph Heritage Healthcare for services provided to me by a St. Joseph Heritage Healthcare affiliated medical group. I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. This signature will also serve as an authorization to release medical information necessary to satisfy payment.

_____ ____/____/____

Signature of Patient (If minor, signature of responsible party) Date

_____ ____/____/____

Print Patient Name Patient Date of Birth