

## Harrison County Hospital REGISTRATION FORM

(Please Print)

Today's date:				Family Dr:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:		Middle:		<input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid
(Former name):		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street address:				Social Security no.:		Home phone no.: ( )	
P.O. box:		City:			State:		ZIP Code:
Employer:		Employer Address:				Employer phone no.: ( )	
Service Needed:	<input type="checkbox"/> ER <input type="checkbox"/> Lab <input type="checkbox"/> Radiology <input type="checkbox"/> Surgery <input type="checkbox"/> Pre Surgery Testing <input type="checkbox"/> Other						
<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the Clerk.)							
Person responsible for bill:		Birth date: / /		Address (if different):			Home phone no.: ( )
Employer:		Employer address:				Employer phone no.: ( )	
Primary insurance:							
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's Relationship to subscriber:		Subscriber's Address (if different):					
Secondary insurance:							
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
<b>IN CASE OF EMERGENCY</b>							
Name:				Address:			
City:				State:		Zip:	
Phone: ( )				Relationship to Patient:			
HIPAA Info: (friends and family the doctor may talk to about your condition)				Power of Attorney: (include phone number)			
<b>Office Use:</b>				Comments:			
Clerk:							

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