SEVEN HILLS HOSPITAL

Place patient label here
Patient Name: ______________________________
Medical Record #: ______________________________

PATIENT REGISTRATION FORM

(Please complete in black ink only)

PATIENT INFORMATION

Last Name First Name Middle Initial			Home #	Work #	Cell #
Email address:				Date of Birth	Age
Address City State ZIP		Sex (circle one) Male Female		Social Security #	
Marital Status	Employer/School	Address	Occupation	Department	
Emergency Contact (Other than someone that lives with you)				Phone #	

RESPONSIBLE PARTY/GUARDIAN (Individual signing this form)

Last Name First Name Middle Initial		Home #	Work #	Date of Birth
Address City State ZIP		Sex (circle one) Male Female	Marital Status	Social Security #
Employer	Employer's Address	Occupation	Department	Relationship to Patient

INSURED PARTY INFORMATION (Spouse or Parent if different from Responsible Party)

Last Name First Name Middle Initial		Home #	Work #
Employer	Employer's Address		Date of Birth
Relationship to Patient	Occupation	Department	Social Security #

PRIMARY INSURANCE INFORMATION

Insurance Company Name	Claims Mailing Address City State ZIP		Phone #
ID#	Group Name and Number	Insured Party	Date of Birth
Effective Date	Deductible/Copay Information	Deductible Met?	Relationship to Patient

SECONDARY INSURANCE INFORMATION

Insurance Company Name	Claims Mailing Address City State ZIP		Phone #
ID #	Group Name and Number	Insured Party	Date of Birth
Effective Date	Deductible/Copay Information	Deductible Met?	Relationship to Patient

I HEREBY GUARANTEE PAYMENT FOR THE ENTIRE BALANCE OF THE ABOVE-NAMED PATIENT. I AUTHORIZE TREATMENT OF THE ABOVE-NAMED PATIENT. I ASSIGN AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO SEVEN HILLS HOSPITAL AND/OR ITS REPRESENTATIVES. I AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING CONFIDENTIAL MEDICAL RECORDS, REQUESTED BY INSURANCE COMPANIES, PAYORS, OR GOVERNMENT AGENCIES IN CONNECTION WITH THIS ASSIGNMENT. TO CANCEL AN APPOINTMENT, THE ABOVE-NAMED PATIENT MUST NOTIFY SEVEN HILLS HOSPITAL AT LEAST 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT TIME, OR ELSE I WILL BE RESPONSIBLE FOR PAYING A $50.00 CANCELLATION FEE. IF THE ABOVE-NAMED PATIENT FAILS TO ATTEND AN APPOINTMENT, I WILL BE RESPONSIBLE FOR PAYING A $50.00 MISSED-APPOINTMENT FEE. I HAVE READ, UNDERSTAND, AND AGREE TO THE DESCRIBED DISCLOSURE, FINANCIAL POLICY, AND VARIOUS RELEASES AND GUARANTEES.

SIGNATURE OF RESPONSIBLE PARTY: ____ DATE: ________________________