HP LONG
A Service of RAPIDES REGIONAL MEDICAL CENTER

PATIENT REGISTRATION FORM

PATIENT NAME (last, first, middle)	Service/Loc	Patient Label

PATIENT

SS#:_____

Address:_____

_____

City:_____ State:____ Zip:_____

Home Ph#:_____ Work Ph#:_____

Birthdate:_____ Mother's Name:_____

Sex: __ M __ F Religion:_____

Marital Status: __ Single __ Married __ Widow/Widower
__ Divorced __ Legally Separated

Race/Ethnicity: __Caucasian __ African American
__ Latin American __ Asian
__ Hispanic __ Other

Email Address:_____

PATIENT EMPLOYER

Name:_____

Address:_____

_____

City:_____ State:____ Zip:_____

Employment Status: __ Full-time __ Part-time

Occupation:_____

EMERGENCY CONTACT

Name:_____ Ph#:_____

_____

City:_____ State:____ Zip:_____

Relationship:_____ Work Ph:_____

GUARANTOR

Name:_____

Address:_____

_____

City:_____ State:____ Zip:_____

Home Ph#:_____ Birthdate:_____

Relationship to Patient:_____ Occupation: _____

Employment Status: __ Full-time __ Part-time

GUARANTOR EMPLOYER

Name:_____

Address:_____

_____

City:_____ State:____ Zip:_____

Work Ph#:_____

Employment Status: __ Full-time __ Part-time

Occupation:_____

INSURANCE #1

Name:_____

Address:_____

_____

City:_____ State:____ Zip:_____

Ph#:_____

INSURANCE POLICY INFORMATION

Policy #:_____

Subscriber:_____

Relationship:_____

Group Name:_____

Group #:_____

WHO REFERRED YOU TO OUR OFFICE?

FAMILY DOCTOR: