

HCA Physician Services Patient Registration Form

(Please Print)

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (MI) _____

Also Known As Name (Last) _____ (First) _____

Date of Birth ____/____/____ Female Male Social Security Number ____-____-____

Phone Numbers Home _____ Cell _____ Work _____

Mailing Address _____

City, State, ZIP (+4) _____

Physical Address (if different from mailing) _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Race American Indian/Alaska Native Asian Native Hawaiian or other Pacific Island Black/African American White/Caucasian

Ethnicity Hispanic or Latino Not Hispanic or Latino Preferred Language: _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

E-Mail Address _____ (used for online surveys only)

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient Mother Father Other: _____

List the names of your child's Parents/Guardians below

Name: _____	Rel: _____	Name: _____	Rel: _____
Name: _____	Rel: _____	Name: _____	Rel: _____

RESPONSIBLE PARTY INFORMATION ***Statements will be addressed to the Responsible Party***

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Also Known As Name (Last) _____ (First) _____

Date of Birth ____/____/____ Female Male Social Security Number ____-____-____

Phone Numbers Home _____ Cell _____ Work _____

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Subscriber _____ Patient Relationship to Subscriber _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Phone Numbers Home _____ Cell _____ Work _____

Address: _____ City/State/Zip: _____

Insurance Plan Name: _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Subscriber _____ Patient Relationship to Subscriber _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Phone Numbers Home _____ Cell _____ Work _____

Address: _____ City/State/Zip: _____

Insurance Plan Name: _____

Primary Care Physician: _____ **Phone:** _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Patient (or Responsible Party) Signature _____ **Date** _____