Holy Family Healthcare

Patient Registration

(PLEASE PRINT CLEARLY)

Patient's Legal Name: _____
Last First Middle

Address: _____
Street Apt#

_____
City State Zip

Date of Birth (Mo/Day/Year): _____ Sex (circle): M F

Home#: (___)_____ Cell#: (___) _____ Other#: (___) _____

Referred by: _____ Previous Clinic: _____

COMPLETE IF PATIENT IS 0 -17 YEARS OF AGE:

Parent/Legal Guardian:_____ Parent/Legal Guardian:_____

Birthdate: _____ Birthdate: _____

Address (if different): _____ Address (if different): _____

_____ _____

Hm Phone: (_____)_____ Hm Phone: (_____)_____

Work Phone:(__)_____ Cell Phone: (___)_____ Work Phone:(___)_____ Cell Phone: (___)_____

Parent's Marital Status (circle): Married Widowed Divorced Single Legally Separated Other

Siblings & Birthdates: _____ _____ _____

INSURANCE INFORMATION:

PRIMARY INS. NAME: _____ **SECONDARY INS. NAME:** _____

Policy Holder: _____DOB:_____ Policy Holder: _____DOB:_____

Sex (circle): M F Sex (circle): M F

Patient's Relationship to Insured: _____ Patient's Relationship to Insured: _____

Policy ID#: _____ Group#: _____ Policy ID#: _____ Group#:_____

Date Coverage Effective: _____ Date Coverage Effective: _____

Copay Y N Amt:_____ CoPay Y N Amt:_____

I agree that the above information is true and correct to the best of my knowledge.

_____ _____ _____
Print Name (Patient or Parent if minor) Signature (Patient or Parent if minor) Date

_____
Relationship to Above Patient