For Hospital Use:

Arrival Date: _____

Arrival Time: _____

Last Name: _____ First Name: _____ D.O.B: _____

DOWNTIME PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS:

LAST NAME: _____ FIRST NAME: _____ PREFERRED NAME: _____

SSN: _____ SEX: _____ GENDER IDENTITY: _____

SEX ASSIGNED AT BIRTH: _____ SEXUAL ORIENTATION: _____DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ WORK#: _____ MOBILE#: _____

EMAIL: _____

MARITAL STATUS: _____ LANGUAGE: _____ RACE: _____

ETHNICITY: _____ RELIGION: _____

COUNTRY OF BIRTH: _____

PATIENT EMPLOYER INFORMATION:

EMPLOYER: _____ EMPLOYMENT STATUS: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ State: _____ ZIP: _____

PCP INFO:

PCP NAME: _____

ADDRESS: _____

CITY: _____ State: _____ ZIP: _____

PHONE#: _____ FAX#: _____

PATIENT CONTACTS:

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME# _____ CELL PHONE#_____

RELATIONSHIP: _____ If A MINOR, LEGAL GUARDIAN? _____

NEXT OF KIN? _____ EMERGENCY CONTACT? _____

GUARANTOR DEMOGRAPHICS:

LAST NAME: _____ FIRST NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME# _____CELL PHONE#_____

SS#_____ DOB_____ EMPLOYMENT STATUS_____

For Hospital Use:

Arrival Date: _____

Arrival Time: _____

Last Name: _____ First Name: _____ D.O.B: _____

COVERAGE INFO:

PRIMARY INSURANCE

INSURANCE NAME: _____SUBCIRBER ID: _____ GROUP NUMBER: _____

CLAIM ADDRESS: _____

MEMBER RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP CODE _____

RELATIONSHIP TO GUARANTOR: _____ PHONE: _____

DOB: _____ SS#: _____ EMPLOYMENT STATUS: _____

SECONDARY INSURANCE

INSURANCE NAME: _____SUBCIRBER ID: _____ GROUP NUMBER: _____

CLAIM ADDRESS: _____

MEMBER RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP CODE _____

RELATIONSHIP TO GUARANTOR: _____ PHONE: _____

DOB: _____ SS#: _____ EMPLOYMENT STATUS: _____

EMERGENCY ROOM REGISTRATION ONLY

EMERGENCY INFO:

MEANS OF ARRIVAL: _____ ESCORTED BY: _____

PRIVATE ENCOUNTER? _____ ACCIDENT RELATED? _____

COMPLAINT:

_____

_____

_____

_____

Registrar: _____ **Date:** _____
Print

_____
Signature