CLINCH RIVER HEALTH SERVICES, INC. **PATIENT REGISTRATION FORM**

PATIENT INFORMATION

Name_____ Soc.Sec.No. _____

Address_____ City_____ State _____ Zip _____

Home Phone_____ Cell Phone_____

Email Address _____ **REFUSED/NONE** (please circle one if not available)

Date Of Birth_____ **Sex :** Male or Female Household Size_____

Marital Status: Single Married Widowed Divorced Separated **Race:** White(not Hispanic), Black (not Hispanic), American Indian, Hispanic(all Races), Alaska Native

PATIENT SPOUSE/GUARDIAN INFORMATION

Spouse/Guardian Name_____

Address_____ City_____ State_____ Zip_____

Relationship_____Phone_____

Employer_____Phone_____

INSURANCE INFORMATION

Primary Insurance_____ Insured Name _____

Secondary Insurance_____ Insured Name_____

RESPONSIBLE PARTY OF ACCOUNT (if different from above)

Name_____ SSN_____--_____--_____

Address_____ City_____ State_____ Zip_____

Employer_____Phone_____

Employer Address_____

City_____State_____Zip_____

PATIENT EMPLOYER INFORMATION

Employer_____ Occupation_____

Address_____ City_____State_____Zip_____

Phone_____Supervisor_____

EMERGENCY CONTACT (Nearest Relative not living with you)

Name_____Relationship_____

Address_____

City_____State_____Zip_____ Phone _____

ALLERGIES:_____

I authorize the release of any and all medical information necessary to process my insurance claim. I permit a copy of this authorization to be used in place of the original. I authorize Clinch Rive Health Services, Inc. to apply for benefits for covered services rendered. I request that payment be made directly to Clinch Rive Health Services, Inc. I certify that the information I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay.

SIGNATURE_____**DATE** _____