Adventist Health Castle

PATIENT REGISTRATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that the information on this form has been uploaded into the EMR.*

PATIENT INFORMATION

First Name:_____ Last Name:_____ Suffix:_____

SSN:_____-_____-_____ Home Phone:_____ Cell Phone:_____

Middle Name:_____ Email Address:_____
** Provide your email and receive updates on your bill, specials, health topics, & more!*

Date of Birth_____/_____/_____ Sex at Birth: ❑M ❑F ❑Other Marital Status: ❑Married ❑Single

Mailing Address:_____ City/State/Zip Code:_____

Suite/Ste/Bldg.:_____

What is your preferred method of communication? ❑ Cell Phone ❑ Home Phone ❑ Email ❑ Mail

Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ YES ❑ NO

How did you hear hear about us? ❑ Drive By ❑ Insurance ❑ Doctor (Referring Physician/Hospital:_____)
❑ Employer ❑ Friend/Family ❑ Hotel ❑ Internet ❑ Instagram
❑ Facebook ❑ First Aid Station/Event (Please specify):_____)

Preferred Pharmacy City:_____ Preferred Pharmacy Zip Code:_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician:_____ Phone Number:_____
❑ *I do not have a primary care physician* ❑ *I don't know who my primary care physician is*

EMERGENCY CONTACT/NEXT OF KIN **Please provide the BEST contact numbers for each contact*

1. Name:_____ Relationship:_____ Phone Number:_____
2. Name:_____ Relationship:_____ Phone Number:_____

PERSONAL INSURANCE COVERAGE

Primary Insurance:_____ Secondary Insurance:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Member ID Number:_____ Member ID Number:_____

Group Number:_____ Group Number:_____

Policy Holders SSN:_____ DOB:___/___/___ Policy Holders SSN:_____ DOB:___/___/___

Relationship to Patient:_____ Relationship to Patient:_____

GUARANTOR'S INFORMATION **Please include your information if you are checking in a patient younger than 18 years old.*

First Name:_____ Last Name:_____

Date of Birth:_____ SSN:_____ Phone Number:_____

Address:_____
Street Address *City/State/Zip Code*

Print Name of Patient/Guardian:_____ Date:_____

Signature of Patient/Guardian:_____