MRN: ____________________

DATE: ____________________

REGISTRATION FORM

St.JosephHealth Medical Group

PATIENT INFORMATION

Patient Name: ____
Last First Middle

Date of Birth: ____________ Sex: _____ Driver's Lic #: ______________ Last 4 digits of SSN: ____________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Race: ☐ American Indian/Alaskan Native ☐ Hawaiian/Pacific Islander ☐ Asian ☐ White
☐ Black/African American ☐ Two or more races ☐ Decline

Mailing Address: ____

City: ______________________________ State: ________ Zip: ______________

Send Appointment Reminder via: ☐ Text ☐ Call Phone #: ________________

Preferred Phone # for Routine Communication: ________________ ☐ Home ☐ Work ☐ Cell

Secondary Phone #: ________________ ☐ Home ☐ Work ☐ Cell

E-mail: ________________ @ ________________ Primary Spoken Language: ______________

Primary Care Provider: ______________________ How were you referred?: ______________

Employer: ______________________________ Employer Phone #: ______________

Employer Address: ______________________ City: ______________ State: ______ Zip: ________

EMERGENCY CONTACT

Contact Name: ______________________________ Relation to Patient: ______________

Contact Address: ______________________ City: ______________ State: ______ Zip: ________

Primary Phone #: ______________________ Secondary Phone #: ______________________

If the patient is a child, please name a secondary contact other than the parent/guardian

Name: ______________________________ Phone #: ______________________

PRIMARY RESPONSIBLE PARTY

☐ I am the primary responsible party (Skip to next section) ☐ Spouse ☐ Guardian ☐ Parent
☐ Other: ______________________

Name: ____

Date of Birth: ____________ Sex: _____ Driver's Lic #: ______________ Phone #: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Employer: ______________________________ Employer Phone #: ______________

Employer Address: ______________________ City: ______________ State: ______ Zip: ________

SECONDARY RESPONSIBLE PARTY

☐ Spouse ☐ Guardian ☐ Parent ☐ Other: ______________________

Name: ____

Date of Birth: ____________ Sex: _____ Driver's Lic #: ______________ Phone #: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Employer: ______________________________ Employer Phone #: ______________

Employer Address: ______________________ City: ______________ State: ______ Zip: ________

MRN: ____________________

St.JosephHealth Medical Group

INSURANCE INFORMATION

Primary Insurance Company Name: ____________________

Subscriber's Name: ____________________ Date of Birth: ____________________

Relation to patient: ____________________

Subscriber's address if other than patient: ____________________

Secondary Insurance Company Name: ____________________

Subscriber's Name: ____________________ Date of Birth: ____________________

Relation to patient: ____________________

Subscriber's address if other than patient: ____________________

ELIGIBILITY GUARANTEE

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I also certify that I have chosen a St. Joseph Heritage Healthcare affiliated medical group to provide healthcare services. I understand that if the above is not true or I am not eligible under the terms of my medical and hospital subscriber agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature: ____________________ **Date:** ____________________

COMMUNICATION CONSENT

By providing the St. Joseph Heritage Healthcare or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that St. Joseph Heritage Healthcare or its service providers may use the provided telephone number or e-mail to service my account(s) (including contacting me about obtaining potential financial assistance for my account(s)), to send the patient appointment and follow-up health care reminders by text or e-mail, to send me information, to schedule patient appointments, and to collect any amounts I may owe to my healthcare provider(s). I understand and agree that St. Joseph Heritage Healthcare and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in charges to me. I expressly consent that methods of contact may include using prerecorded and artificial voice messages, text, email (if an email address has been provided), and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with my account number(s) and is not a condition of purchasing property, goods, or services. I am not required to sign this consent as a condition of receiving healthcare services.

____________ **Initials/Approve** ____________ **Initials/Decline**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to St. Joseph Heritage Healthcare for services provided to me by a St. Joseph Heritage Healthcare affiliated medical group. I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. This signature will also serve as an authorization to release medical information necessary to satisfy payment.

____________________ ____________________

Signature of Patient (If minor, signature of responsible party) **Date**

____________________ ____________________

Print Patient Name **Patient Date of Birth**