

Patient Registration (Please Print)

MRN: _____

Patient Information					
Last Name		First Name		Middle Initial	Date of Birth
Address		Apt #	City		State Zip
Home Phone		Day Phone	Cell Phone	E-mail	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #		Driver's License #		Preferred Language
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner	Preferred Contact Method <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Patient Portal (Secure E-mail)	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Some Other Race <input type="checkbox"/> Two or More Races		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Employer			Occupation		
Employer Address			Employer Phone #		
Responsible Party (Guarantor)					
Last Name		First Name		Middle Initial	Date of Birth
Address (if different from patient)		Apt #	City		State Zip
Home Phone		Day Phone	Cell Phone	E-mail	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN #	Driver's License #		Relation to Patient	
Emergency Contact (If different from responsible party)					
Last Name		First Name		Middle Initial	Date of Birth
Address (if different from patient)		Apt #	City		State Zip
Emergency Phone #		Alternate Phone #		Relation to Patient	
<p>I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the MemorialCare Medical Foundation affiliated medical groups to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize my MemorialCare Medical Foundation affiliated medical group to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.</p>					
_____ Signature of Patient /Responsible Party			_____ Date		
_____ Name of Patient/Responsible Party (please print)			_____ Relationship to Patient		