PATIENT REGISTRATION
(PLEASE COMPLETE THIS FORM IN ITS ENTIRETY)

PATIENT INFORMATION:

Birth Date: _____ Marriage Status: _____ Sex: _____

Name: _____ SSN: _____-_____-_____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Employer_____ Email:_____

RESPONSIBLE PARTY INFORMATION: (If you are the patient you may put SAME AS ABOVE)

Birth Date: _____ Marriage Status: _____ Sex: _____

Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Employer_____ Email:_____

*** * * * PLEASE PRESENT CURRENT INSURANCE CARDS TO THE RECEPTIONIST * * * ***

Emergency Contact: name of Local Friend or Relative (not living at the same address)

Name: _____ Relationship:_____ Contact Person Gender: _____

Contact DOB:_____ Phone: _____ Cell: _____

I consent to the use of disclosure of my protected health record by my Provider at the Daviess Community Hospital Clinics for the purpose of diagnosing or rendering treatment to myself or my dependent, acquiring payment for my health care claims, or to perform health care procedures. I hereby assume payment of all charges and authorize and direct payment from any insurance company to include but not limited to Medicare, Medicare Supplements, made directly to my Provider at Daviess Community Hospital Clinics in agreement with Federal, State, local and agency, I agree to pay collection agency fees, and reasonable attorney and/or court costs.

I UNDERSTAND MY COPAY IS DUE AT EACH VISIT. IF I AM UNABLE TO MAKE THE REQUIRED COPAYMENT, THE APPOINTMENT MAY BE RESCHEDULED.

SIGNATURE OF PATIENT/PARTEN/GUARDIAN:_____Date:_____

If the above signature does not belong to the patient, please list your relationship:_____