Southeast Alabama Rural Health Associates

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date_____ Account#_____ Chart #_____ Insurance Class_____

Patient's Name_____ Birthdate_____
Last First Middle Month-Day-Year

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Sex_____ Race_____ Patient's Social Security #_____

Patient's Employer_____ Work Phone #_____

Person to contact in case of an emergency_____ Emergency Phone #_____

How did you learn of our center?_____

PAYMENT POLICY

Name_____ Relationship to Patient_____

Address_____ Home Phone #_____

Employer_____ Employer's Phone #_____

Employer's Address_____

Mother's Name_____ Social Security #_____

Employer_____ Employer's Phone #_____

Employer's Address_____

Father's Name_____ Social Security #_____

Employer_____ Employer's Phone #_____

Employer's Address_____

INSURANCE INFORMATION

Subscriber or Policy Holder_____ DOB:_____
Relationship to Patient_____
Insurance Type:
___Blue Cross/Blue Shield ___ PMD ___Medicaid ___ Medicare ___Champus ___Other

Policy#_____ Group #_____

Language Best Served In_____ Agricultural Status_____