

Registration Form



MR# _____

Hippa Completed: Yes or No
 Insurance Card Copied: Yes or No
 License Reviewed: Yes or No
 Privacy Patient: Yes or No

Expected Due Date: _____

PATIENT INFORMATION

Patient Name (Last, First, MI)		Maiden Name
Home Address (Street, City, State, Zip Code)		
Mailing Address, if different (Street, City, State, Zip Code)		Home Telephone # Cell #
Date of Birth	Place of Birth (State in USA or Country)	Social Security #
Marital Status: Circle One Single Married Divorced Widowed Separated Other:	Religious Preference	Church Affiliation
Race <input type="checkbox"/> Asian & Oriental <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> White/Caucasian	<input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Native American <input type="checkbox"/> Multi Racial <input type="checkbox"/> Unknown/Refused to Answer	Primary Language Spoken at Home: English Spanish Other: Interpreter Needed: Language Line Needed:
Ethnicity	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No** **Other:	Primary Care Physician
OB Dr's or Midwife's Name & Practice: <input type="checkbox"/> Bedford Womens <input type="checkbox"/> Dart. Hitch. Midwives <input type="checkbox"/> Pregnancy Care Center <input type="checkbox"/> Other:	Follow Up Baby Dr's Practice Name: <i>Bring mailing address info with you to hospital or complete below</i> Phone # Fax # Address: City: State: Zip Code:	
List anything you are allergic to: Food or Medicine	Have you ever been treated at Catholic Medical Center before? <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Current Employer's Name	Work Telephone and Ext.	
Employer/Work Address (Street, City, State, Zip)		
Occupation/Job Title		

INSURANCE INFORMATION

*** Please have your insurance card & license available for us at all visits. ***
 I do not have health insurance and would like information on my options

Primary Insurance Name	ID Number	Group Number/Policy Number (or Medicaid/Healthy Kids Card Number)
Subscriber's Name (who carries the insurance) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent		
Secondary Insurance (if applicable)	ID Number	Group Number/Policy Number (or Medicaid/Healthy Kids Card Number)
Subscriber's Name (who carries the insurance) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent		

ADDITIONAL CONTACT INFORMATION

Spouse or Significant Other's Name (Parent's Name if patient is a minor)		Do you have a Suffix after your name: <input type="checkbox"/> Yes* or <input type="checkbox"/> No	
		*If Yes: what is it? Jr. Sr. I II III Other:	
Home Address (Street, City, State, Zip Code) <input type="checkbox"/> CHECK HERE IF SAME AS PATIENT			
Home Telephone #		Spouse or Significant Others Date of Birth (required)	Spouse or Significant Other's Place of Birth: State in USA: _____ or Country: _____
Cell #			
Spouse or Significant Other's Social Security # (required)		Sex (Circle One) Male Female	Relation to Patient: Spouse Partner Parent Other
Religious Preference	Church Affiliation	Ethnicity	US Citizen <input type="checkbox"/> Yes or <input type="checkbox"/> No** ** Other:
Race <input type="checkbox"/> Asian & Oriental <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Native American <input type="checkbox"/> Other <input type="checkbox"/> Multi Racial <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Unknown/Refused to Answer			
Primary Care Physician		Spouse or Significant Other's Current Employer (IF SELF EMPLOYED—NEED BUSINESS NAME)	
Spouse or Significant Other's Employer Address (Street, City, Zip)		Spouse or Significant Other's Occupation/Job Title	
Work Telephone and Ext.			

ALTERNATE EMERGENCY CONTACT INFORMATION

Person to notify in case of emergency <input type="checkbox"/> Check if same as above If not same as additional contact then complete below		Relationship
Name: Last, First, Middle	Daytime Telephone #	Date of Birth of Contact:
Full Address of emergency contact	Alternate Telephone #	

ADVANCED DIRECTIVES: You are not required to have an Advance Directive to be admitted. Federal law requires the hospital to ask the following questions and document your response in your medical file at Catholic Medical Center.

Do you have a Living Will? Yes* No

Do you have a Durable Power of Attorney for Health Care? Yes* No

*If you answered Yes to any of the above—You must supply us a copy for your file.

Is there a copy at the hospital? Yes No

RESPONSIBLE PARTY INFORMATION

The responsible party is yourself, unless you are under 18, or have a legal guardian.

Are you over the age of 18? If YES, check here Patient is responsible party
 If NO. . . What is your relation to the responsible party? (check below)
 Parent Spouse Child Student over 18 Other:

Full Name of Responsible Party	Home Telephone	Work Telephone and Ext.	Social Security #
Address of Responsible Party (Street, City, State Zip)			Date of Birth
Name and Address of Employer of Responsible Party		Employer Phone #	Occupation/Job Title
Whom may we thank for referring you to The Mom's Place?			

NOTES: