Patient Registration

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI: ________

Preferred Name: ______________________ Date of Birth: ______________ Sex: ☐M ☐F ☐Other

Mailing Address: ____

City, State, Zip: ______________________ Social Sec. #: ______________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Other Race: ______________________

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino Preferred Language: ______________

Referring Provider: ______________________ Preferred Pharmacy: ______________________

Primary Care Provider: ______________________ Preferred Lab & Imaging: ______________

CONTACT INFORMATION

Home#: ______________ Mobile#: ______________ Work#: ______________ Contact Preference:

OK to leave detailed message: ☐Home ☐Mobile ☐Work Email Address: ______________________

I would like to receive automated notifications via: ☐Phone ☐Text ☐Email ☐None

Emergency Contact: ______________________ Relationship: ______________ Ph. #: ______________

KHCA is authorized to discuss my medical condition with the following non-medical individuals:

Name/Relationship: ______________________ Ph.#: ______________ ☐Medical ☐Billing ☐Scheduling

Name/Relationship: ______________________ Ph.#: ______________ ☐Medical ☐Billing ☐Scheduling

PATIENT EMPLOYER INFORMATION

☐ Employed ☐Retired ☐Unemployed ☐Disabled ☐Other

Employer: ______________________ Occupation: ______________ Ph.#: ______________

RESPONSIBLE PARTY

☐Self ☐Spouse ☐Other ______________________

Last Name: ______________________ First Name: ______________________ Ph. #: ______________

INSURANCE COVERAGE	**Primary Insurance**	**Secondary Insurance**
Name of Insurance Company:	______________________	______________________
Policy Holder:	______________________	______________________
Policy Holder's Date of Birth:	______________________	______________________
Policy Holder's Social Sec.	______________________	______________________
Relationship to Insured:	☐Self ☐Spouse ☐Child ☐Other	☐Self ☐Spouse ☐Child ☐Other
Policy Number:	______________________	______________________
Group Number:	______________________	______________________

Certification of Accuracy, Authorizations & Guarantee of Account

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to KHCA. I understand that I am financially responsible for all services rendered to me whether they are or are not covered by my Insurance. I further understand that I am financially responsible for any balance, including deductible, copayment, and coinsurance. I authorize KHCA or Insurance Company to release any information required to process my claims.

______________________________ ______________________

Signature of Patient or Patient Representative **Date**

Provider Use Only

Form will expire on: ______________ Staff Initials: ________ Date: ______________