Patient Registration

We are pleased to welcome you to our office. Please take a few minutes to completely fill out this form. If you have any questions we'll be glad to help you.

1. Patient Information

Last Name ____ First Name ____ MI ____ Email Address ____

Date of Birth ____ Place of Birth ____ Date When Moved to County ____ Social Security # ____

Gender: ☐ Female ☐ Male ☐ Transgender

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic ☐ Non-Hispanic or Latin

Race:
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Unknown

Spoken Language: ____________________

How well do you speak English?
- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at all

2. Tribal Membership Information

Tribe of Membership ____ Roll Number ____ Certificate of Indian Blood (CIB) ____ State Where Enrolled ____

3. U.S. Veteran Status

Are you a U.S. Veteran? ☐ Yes ☐ No

Service Entry Date ____ Service Separation Date ____ Vietnam Service ____

4. Home Address & Phone

Check this box if information is the same for the entire family: ☐

Home Address ____ City ____ State ____ Zip ____ Phone ____

Mailing Address same as above ☐ *Mailing* Address ____ City ____ State ____ Zip ____

5. Employment Status

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student

Occupation ____ Employer Name ____ Employer Address ____

6. Emergency Contact

Who should we call in case of an emergency?

First Name ____ Last Name ____ Phone ____ Relationship ____

7. Minor Contact

If the patient is a minor, please indicate the following family information.

(Father) First Name, Last Name ____ Place of Birth (City & State) ____

(Mother) First Name, Last Name ____ Place of Birth (City & State) ____ Mother's Maiden Name ____

8. Contact Preferences

How would you like us to contact you about your appointments? ☐ Home Phone ☐ Work Phone ☐ Cell ☐ Email

Do you have internet access? ☐ Yes ☐ No What kind of internet access do you have? ☐ Home Access ☐ Mobile

Would you like to have communications sent to you via email? (i.e. appointment reminders, updates, bulletins) ☐ Yes ☐ No

How did you hear about us? ______________________________

9. Guarantor Information

Please complete if you are the parent or another party responsible for paying the bill.

First Name (Guarantor) | Last Name (Guarantor) | Home Phone | Language

Address | City | State | Zip

Date of Birth | Social Security # | Email Address

Occupation | Employer Name | Employer Address

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian/Conservator

10. **Dental** Insurance Information

a. Primary Insurance

Subscriber Name | Subscriber ID#

Social Security # | Date of Birth

Insurance Company | Insurance Phone #

Group Name | Group #

Employer | Relationship to Subscriber

b. Secondary Insurance

Subscriber Name | Subscriber ID#

Social Security # | Date of Birth

Insurance Company | Insurance Phone #

Group Name | Group #

Employer | Relationship to Subscriber

**Please present insurance card to receptionist*

11. **Medical** Insurance Information

a. Primary Insurance

Subscriber Name | Subscriber ID#

Social Security # | Date of Birth

Insurance Company | Insurance Phone #

Group Name | Group #

Employer | Relationship to Subscriber

b. Secondary Insurance

Subscriber Name | Subscriber ID#

Social Security # | Date of Birth

Insurance Company | Insurance Phone #

Group Name | Group #

Employer | Relationship to Subscriber

**Please present insurance card to receptionist*

12. Acknowledgment

Is your visit due to a job-related injury or automobile accident? ☐ Yes ☐ No

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Rolling Hills Clinic. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Name of Patient (or Guardian) *(print)* | Signature | Date

Official Use Only:

	Yes	No
Proof of Guardianship Received	☐	☐
Scanned/Copied to Chart	☐	☐

Signature of Witness | Date