Sentara

Physician Practices

Patient Registration Form

Last Name_______________ First Name_______________ MI_____

AKA (Also Known As) /Previous Last Name(s)_______________

Social Security #_____-_____-_____ Date of Birth_____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ___Married ___Single ___Divorced ___Legally Separated ___Widowed ____ Life Partner

Home Address _______________

____

City_______________ State__________ Zip Code__________

Home Phone(_____)_______________ Cell Phone(_____)_______________

Alternate Phone(_____)_______________ Alternate Phone Info _______________

E-Mail_______________

Patient/Family Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Alt Phone ☐ E-Mail ☐ Text

Primary Care Physician/Pediatrician_______________

If pediatric patient, please list siblings _______________

____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Pacific Islander or Native Hawaiian ☐ Other Race – Please Print_______________

Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

☐ Other/Unknown – Please Print if Other_______________

Language Preference: If other than English- Please Print_______________

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication?

If yes, Please check appropriate item(s): ☐ Vision ☐ Hearing

Patient's Employer_______________

Address_______________

City_______________ State__________ Zip Code__________

Work Phone Number(_____)_______________ Ext__________

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients ☐ Guarantor? ☐ Legal Guardian?

Guarantor/Legal Guardian Name_______________ Social Security #_____-_____-_____

Patient's Relationship to Guarantor/Legal Guardian: ☐ Spouse ☐ Dependent Child ☐ Student

Date of Birth _____/_____/_____ ☐ Other – Please Print_______________

Guarantor/Legal Guardian Home Address____

____

City____________________________________State ______Zip Code__________________

Home Phone (______)__________________ Cell Phone(______)________________ Work Phone(_____)________________________

Guarantor/Legal Guardian Employer Name & Address____________________________________

____

City___________________________ State___________ Zip Code_______________

Emergency Contact - Who to call in the event of an Emergency

1. Name________________________________ Relationship___________________________

   Cell/Hm Phone #(______)__________________________ Work Phone #(______)__________________________

2. Name________________________________ Relationship___________________________

   Cell/ Hm Phone #(______)__________________________ Work Phone #(______)__________________________

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

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) ☐ Yes ☐ No

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Does the patient have insurance? ☐ Yes ☐ No

Primary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Primary Insurance***

Plan Name____

Policy Holder's Name____ Gender: ☐ Male ☐ Female

Policy Holder's #______-________-___________ Policy Holder's Date of Birth ______/_______/_______

Secondary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Secondary Insurance***

Plan Name____

Policy Holder's Name____ Gender: ☐ Male ☐ Female

Policy Holder's #______-________-___________ Policy Holder's Date of Birth ______/_______/_______

Patient/Guarantor Printed Name____

Patient/Guarantor Signature______________________________________ **Date**_______/__________/_______