AMITA HEALTH

PATIENT REGISTRATION FORM

If you are an *Immediate Care (unscheduled)* patient, please complete this section.

Do you have a primary care provider? **NO** **YES** (Please circle) **Name of Physician:** _____ **Phone Number:** _____

Reason for visit/ Brief description: _____ **Is it work related?** _____

Patient Name: _____ _____ _____
Last Name M.I. First Name

Date of Birth: _____/_____/_____ **Sex:** ☐ **Male** ☐ **Female** **Social Security Number:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Work Number: _____

Home Address: _____ Apt #: _____ **Email Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

PRIMARY INSURANCE INFORMATION

Primary Health Insurance Company: _____ **Subscriber Name:** _____

Patient's Relationship to Insured: _____ **Subscribers Date of Birth:** _____/ _____/_____

Subscriber's ID # : _____ **Group #:** _____

SECONDARY INSURANCE INFORMATION (if applicable)

Primary Health Insurance Company: _____ **Subscriber Name:** _____

Patient's Relationship to Insured: _____ **Subscribers Date of Birth:** _____/ _____/_____

Subscriber's ID #: _____ **Group #:** _____

How did you learn of our practice?

☐ **Friend/ Family** ☐ **Post Card/ Mailing** ☐ **Insurance Company** ☐ **Healthgrades** ☐ **Yellow Pages**

☐ **Physician:** _____ ☐ **InQuicker** ☐ **Alexian Connects** ☐ **Other:** _____

Preferred Pharmacy: _____ **Address:** _____

WORK RELATED INJURY: IF YOU HAD A WORK RELATED INJURY RELATED TO THIS VISIT, PLEASE COMPLETE THIS SECTION

Employer/Responsible Party: _____ **Company Contact Name:** _____

Company Phone: _____ **Employer Address:** _____

Date of Injury _____ **Do you work for a Temp Agency?** _____ **Name & Address** _____