

Patient Registration Form – Altus Hospital

Patient Information

Patient Last Name		First Name	Middle Name	Alias Name
Address (Street or Box)			City	State Zip
Home Phone:		Work Phone:	Mobile Phone :	
E-mail (Allows us to send you important messages.)			How and Where Did You Learn About This Hospital:	
Social Security Number:			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Driver's License #:			Condition/Illness Related to: <input type="checkbox"/> Illness <input type="checkbox"/> Employment <input type="checkbox"/> Auto <input type="checkbox"/> Other	
Relation to Insurance Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Do You Have Any Medical Directives: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian/Eskimo/Aleut <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other _____			Ethnicity: <input type="checkbox"/> Hispanic/Latino Origin <input type="checkbox"/> Non-Hispanic/Latino Origin	

Insurance & Subscriber Information

Primary Insurance Company			Effective Date		Secondary Insurance Company			Effective Date	
Claims Mailing Address (Street or Box)					Claims Mailing Address (Street or Box)				
City		State	Zip	City		State	Zip		
Policy ID Number			Group ID Number		Policy ID Number			Group ID Number	
Subscriber Name (policy holder)			Date of Birth		Subscriber Name (policy holder)			Date of Birth	
Subscriber Social Security #			Relationship to Patient		Subscriber Social Security #			Relationship to Patient	
Subscriber Employer			Work Phone #		Subscriber Employer			Work Phone #	
Subscriber Employer Address (Street or Box)					Subscriber Employer Address (Street or Box)				
City		State	Zip	City		State	Zip		

Additional Medical Information

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No Your Initials: _____

If you answered yes, please fill out the accident specific form, available at the front desk.

Are you pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Physician:
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Emergency Contact Information:

Person's Name _____ Relationship to Person _____

Phone Number _____

**AFFIX PATIENT INFO LABEL
HERE
Date of Service will be present on
patient sticker**