Good Samaritan Physician Network

PATIENT REGISTRATION

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S.S. #: _____ Age: _____

Patient **Legal** Name: _____ (Nickname) _____
(Last) (First) (M.I.)

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell #:_____

Gender: Male _____ Female _____ Date of Birth: _____

Patient Employer: _____

Employer Address: _____ City: _____ ST: _____ Zip: _____

E-mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referred by: _____ Primary Care Provider: _____
(What medical provider suggested you come to our clinic?) *(If applicable)*

Marital Status: Married _____ Divorce _____ Single _____ Widowed _____

Race: _____ Ethnicity: _____ Primary Language: _____
(Indian, Asian, Pacific Islander African American, Hawaiian, more than 1, white, refused) (Latino/Hispanic, Not Latino/Hispanic, refused) (English, Spanish, French German, Russian, Polish Other)

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Spouse _____ Parent _____

Name: _____
(Last) (First) (M.I.)

Address: _____ City: _____ ST: _____ Zip: _____

Primary Phone: _____ Work Phone: _____Cell #:_____

Date of Birth: _____S.S #: _____

Employer: _____

Employer Address: _____ City: _____ ST: _____ Zip: _____

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THE FOLLOWING INFORMATION IS REQUIRED TO BILL YOUR INSURANCE. PLEASE COMPLETE ALL SECTIONS.

Primary Insurance Co: _____ Policy ID #: _____

Employer Name: _____ Group #: _____

Policyholder **Legal** Name: _____
(Last) (First) (M.I.)

Address: _____ City: _____ ST: _____ ZIP: _____

DOB: _____S.S. #: _____Relationship: _____

Secondary Ins. Co : _____ Policy ID #: _____

Employer Name: _____ Group #: _____

Policyholder **Legal** Name: _____ DOB: _____
(Last) (First) (M.I.)

Address: _____ City: _____ ST: _____Zip;_____

S.S. #: _____ Effective Date: _____ Relationship _____

DOB: _____S.S. #: _____Relationship_____

Worker's Comp Yes _____ No _____

SIGNATURE: _____ DATE: _____