EXCELLHEALTH

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name (Last):_____ First:_____ Middle Initial: _____

Address:_____
Street City State Zip

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

Date of Birth: _____ Sex (circle one): Male Female Transgender

Marital Status (circle one): Single Married Partner Divorced Separated Widowed

Race: _____White
_____Black/African American
_____Hispanic/Latino
_____Native American
_____Other: _____

Language: _____English
_____Spanish
_____Chinese
_____Other:_____

Social Security Number: _____-_____-_____ Employer Name:_____

Employment Status (circle one): Full-Time Part-Time Not-Employed Self-Employed Retired Military

Student Status (circle one): Full-Time Student Part-Time Student Not a Student

Emergency Contact: Last Name_____ First Name:_____

Phone Number: _____ Relationship: _____

Address: _____
Street City State Zip

Primary Care Provider: _____ Referring Provider: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ____Self (information same as above) ____Guarantor ____Another Patient

Responsible Party Name: (Last)_____ First:_____ Middle Initial:_____

Address:_____
Street City State Zip

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

Date of Birth: _____ Sex (circle one): Male Female Transgender

Guarantor Account Number:_____ Social Security Number _____-_____-_____

Employer: _____ Employer Phone Number: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Name of Insured: _____ Policy Number: _____

Group ID:_____ Copay Amount: _____

Effective Date: _____ Termination Date: _____

Patient Relationship to Insured (If not Patient): _____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company: _____ Phone Number: _____

Name of Insured: _____ Policy Number: _____

Group ID:_____ Copay Amount: _____

Effective Date: _____ Termination Date: _____

Patient Relationship to Insured (If not Patient): _____ Date of Birth: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient/Responsible Party Signature: _____ Date: _____