REGISTRATION INFORMATION

Patient Name:_____ M/F/Transgender_____ DOB_____

Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Cell Phone:_____ Email:_____

School:_____ Grade_____ Marital Status:_____ Race:_____

SS#:_____ Religion:_____ Employer:_____

Employer Phone:_____ Stats: FT/PT/RETIRED

PARENT/GUARANTOR/GUARDIAN WHO WILL SIGN CONSENTS FOR TREATMENT:

Name:_____ Relationship:_____ DOB:_____

Address:_____ City_____ State_____ Zip_____

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

Other Contact person (other parent/guardian or additional emergency contact): (Optional)

Contact:_____ Relationship:_____

Address:_____ City_____ State_____ Zip_____

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

WHO CARRIES THE INSURANCE POLICY:

Name:_____ DOB:_____ SS#:_____

Primary Insurance:_____ ID#:_____

Relationship to patient:_____ Address (if different than patient)_____

Policy holder's Employer:_____ Employer phone:_____

Position of Employment:_____ Status: FT PT Retired Other

Secondary Insurance: Yes No

Name of secondary insurance: _____ ID#:_____

Relationship to patient:_____ Address (if different than patient)_____

Policy holder's employer:_____ Employer phone:_____

DOMINION HOSPITAL

Patient Information/Label