CLINIC PATIENT REGISTRATION FORM }

Date_____

St. James Parish Hospital welcomes you to our clinics. We are committed to providing the best, most comprehensive care possible and encourage you to ask questions. Please assist us by providing the following information which is confidential and released only with your consent.

PATIENT NAME	***DATE OF BIRTH***	***SOCIAL SECURITY #***

PLEASE CIRCLE }

Status: Married / Single / Divorced / Separated / Widowed **Race**: African Am. / White / Other

Language: English / Other _____ **Ethnicity**: _____ **Sex**: M / F **Age:** _____

Parent *(if Patient Is a Minor)* **Email Address**

Mailing Address **City** **State** **Zip**

Home Telephone **Work Telephone** **Cell Number**

NOTIFY IN CASE OF EMERGENCY

Name Relationship to Patient

Home Telephone Work Telephone Cell Number

FINANCIAL INFORMATION (person responsible for fees if different than above)

Name Telephone

Mailing Address City State
Zip

Guarantor(s):_____ **Relationship to Patient:**_____
DOB: _____ **Social Security#:** _____

Primary Insurance Company

Subscriber's Name: **Subscriber's Date of Birth:**

Secondary Insurance Company Claim Address

Subscriber's Name: **Subscriber's Date of Birth:**

Whom May We Thank for Referring You to Our Practice?

Release of Medical Information/Assignment of Benefits/Financial Agreement/Consent for Treatment

I, UNDERSTAND THAT I PATIENT (OR LEGAL GUARDIAN) AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE MY INFORMATION TO THE INSURANCE, FILLING OR ANYONE ELSE TO SECURE THE PAYMENT OR BENEFITS.

X

_____ _____

Patient or Parent/Guardian Signature **Date**

PATIENT CONSENT OF TREATMENT }

I hereby authorize this clinic to administer or perform medical treatment including procedures or services as they may deem necessary or reasonable, including chest x-ray, laboratory services and diagnostic procedures I hereby consent thereto.

Patient Signature / Authorized Person _____ **Date** _____