

Registration Information

Please print

Veteran: yes ___ No ___

Hispanic: yes ___ No ___ E-mail address _____

Patient Name _____ Date of Birth ____/____/____

____ Sex _____

Last First MI

Address _____ Lot/Apt # _____ City

_____ State _____ Zip _____

Home Phone # _____ Social Security # _____ Drivers license #

Place of Employment _____ Work Phone

Marital Status _____ Spouse's Name _____ Date of Birth

____/____/____

Spouse's Social Security # _____ Work Phone # _____

Language spoken in home _____

Please mark race:

____ Asian ____ Alaska Indian (including American Indians or Alaska Natives / Hispanic Descent)

____ Native Hawaiian ____ Black (including Blacks or African Americans of Latino / Hispanic Descent)

____ More than one race ____ White (including Whites of Latino / Hispanic Descent)

____ Pacific Islander ____ Unreported / Refuse to report

Responsible Party _____ Date of

Birth ____/____/____

Address _____ Lot/

Apt# _____ City _____ State _____ Zip _____

Social Security # _____ Home Phone # _____ Relation to

Patient _____

Place of Employment _____ Work Phone

In case of emergency, whom shall we call? _____ Phone

Please list personal contacts

Can we share your medical and account information with these contacts? Yes _____ No _____

Name _____ Relationship _____ Phone # _____

Address _____ Lot/
Apt# _____ City _____ State _____ Zip _____

Name _____ Relationship _____ Phone # _____

Address _____ Lot/
Apt# _____ City _____ State _____ Zip _____

Insurance Information (Including Medical card)

None _____ Primary _____

Insurance _____ Family _____ Single _____

ID# _____ Group # _____

Name of Policy Holder _____ Effective Date _____

Address of policy holder _____ Lot/Apt # _____ City _____ State _____ Zip _____

Social Security # of policy holder _____ Date of Birth for policy holder _____ / _____ / _____

Secondary Insurance _____ Effective Date _____

Continued on Reverse (Signature required on reverse side)

- I consent to the performance of examination, treatment, laboratory tests and medical procedures that may be advisable in the opinion of the attending medical personnel of the PrairieStar Health Center.
- I authorize the release of medical information necessary to secure the payment of Insurance benefits. I directly assign all medical benefits to the PrairieStar Health Center and understand I am financially responsible for all charges not paid by my Insurance.
- If the patient is under 18 years old, a parent or guardian must sign. If a parent or guardian is not present in the clinic, a consent to treat form must be signed by the parent / guardian.

- I have received notice of this organization's privacy practices.
- I have read and fully understand the above statements.
- I certify that the information given on this form is true and accurate. This may be verified.

Signature of Patient or guardian Date