Registration History

	Encounter#	ECD#	MR#

SCHEDULING INFORMATION

Date of Service:	Resource:	Activity:	Sch Loc:

PATIENT INFORMATION

PATIENT NAME:
ADDRESS:
C/S/ZIP:
COUNTY: PHONE
DOB: SOC SEC #:
AGE: RACE: REL:
SEX: MARITAL STATUS:
PREFERRED PHONE:
EMAIL:

REGISTRATION INFORMATION

DATE REG:
TIME REG:
ENC LOCATION:
CLINICAL SVC:
ARRIVAL MODE:
CONFIDENTIALITY REASON:
PSX#

EMERGENCY CONTACT INFORMATION

NAME:
PHONE 1: RELATIONSHIP TO PT:

NEXT OF KIN CONTACT INFORMATION

NAME:
PHONE 1: RELATIONSHIP TO PT:

PATIENT EMPLOYER

EMPLOYER:
ADDRESS:
PHONE 1:

GUARANTOR INFORMATION

NAME:
PT RELATIONSHIP TO GUARANTOR:
ADDRESS:
C/S/ZIP:
PHONE 1: PHONE 2:

INSURANCE INFORMATION

Insurance 1 Name, Address, Phone **Self Pay:**	Policy Number	Group Number	Subscriber
	Referral/Auth #	Auth Phone	DOB Employer
	Effective Date	Eligibility Phone	
Insurance 2 Name, Address, Phone	Policy Number	Group Number	Subscriber
	Referral/Auth #	Auth Phone	DOB Employer
	Effective Date	Eligibility Phone	
Insurance 3 Name, Address, Phone	Policy Number	Group Number	Subscriber
	Referral/Auth #	Auth Phone	DOB Employer
	Effective Date	Eligibility Phone	

INCIDENT:

REASON FOR ENC:

Appointment Comment:

PHYSICIAN INFORMATION

ATTENDING:
PHY #:
PHONE:

REFERRING:
PHY #:
PHONE:

PCP:
PHY #:
PHONE: