CATHOLIC HEALTH INITIATIVES

Franciscan Medical Group

A Part of Franciscan Health System

Patient Registration Form

For office use only: Account #: Patient # ☐ New ☐ Update

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last Name: ______ Marital Status: ☐ Single ☐ Married ☐ Other

First Name: ______ M.I.: ______ Student Status: ☐ Full ☐ Part

Social Security#: ______ Sex: ☐ M ☐ F

Address: ______ Date of Birth: ______

City: ______ State: ______ Zip: ______ Home Ph: ______

Employer Name: ______ Cell Ph: ______

Address: ______ City/State: ______ Work Ph: ______

Did another Provider refer you? YES☐ NO☐ Email Address: ______

Referring Provider: **Primary Provider (PCP):**

GUARANTOR INFORMATION *(PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE)*

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Last Name: ______ Home Ph: ______

First Name: ______ M.I.: ______ Cell Ph: ______

Social Security # ______ Work Ph: ______

Address: ______ Employer: ______

City: ______ State: ______ Zip: ______ Address: ______

Relation to Patient: ______ City: ______

Email Address: State: Zip:

Was this a Work Related injury? L&I: YES☐ NO☐ **Was this a Motor Vehicle Accident? MVA: YES☐ NO☐**

Insurance Information	**Primary Insurance**	**Secondary Insurance****	**Other Insurance**
Insurance Name:			
Name of Policy Holder:			
Policy Holder's Employer:			
Subscriber ID #:			
Group and/or Member #:			
Co-payment required:			
Policy Holder's Sex:	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE
Policy Holder's Date of Birth:			
Relationship to patient:			
Insurance Effective Date:			

Medicare patients only –Please check appropriate box →

☐ **Supplemental insurance is provided by patient (MG)**

☐ **Supplemental insurance is provided by former employer**

Emergency Contact: ______ **Phone Number(s):** ______

Relation to Patient: ***(Other than home)***

"I am not receiving DSHS medical assistance and I agree to pay for services. If I later become eligible for DSHS medical assistance for the date of this service, I agree to notify the providers billing office."

Patient or Guarantor Signature: ***Date:***

The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical service and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made. I authorize the physician and clinic to release any information to process insurance claims. I also authorize my insurance to be paid directly to the clinic.

Patient or Guarantor's Signature: ______ **Date:** ______

Please Print Patient/Guarantor's Name:

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REQUEST FOR ADDITIONAL DEMOGRAPHIC INFORMATION

Franciscan Medical Group is now required under Federal and CMS regulation to request information from you regarding your race/ethnicity and preferred language. Although, as a healthcare provider we are required to request this information from you, it is understood that you have the right to choose not to disclose such information.

Race / Ethnicity

Please choose as many as apply

- ☐ **American Indian or Alaskan Native**
- ☐ **Asian**
- ☐ **Black or African American**
- ☐ **Native Hawaiian or other Pacific Islander**
- ☐ **Hispanic**
- ☐ **White**
- ☐ **Other Race or Ethnicity** ____________________

Preferred Language

- ☐ **English**
- ☐ **Arabic**
- ☐ **Armenian**
- ☐ **Chinese**
- ☐ **French**
- ☐ **German**
- ☐ **Greek**
- ☐ **Gujarati**
- ☐ **Hindi**
- ☐ **Italian**
- ☐ **Japanese**
- ☐ **Korean**
- ☐ **Persian**
- ☐ **Polish**
- ☐ **Portuguese**
- ☐ **Russian**
- ☐ **Spanish**
- ☐ **Tagalog**
- ☐ **Urdu**
- ☐ **Vietnamese**
- ☐ **Other** ____________________

☐ Decline to provide information

Patient Label