Shiloh Clinic P.L.C.

PATIENT REGISTRATION FORM

Patient Name_____ Social Security No._____-_____-_____
Date of Birth:_____/_____/_____ Sex: M / F (Circle One) Married/Single/Divorced/Widow
Mailing Address: _____
(Street) *(City/State/Zip)*
Physical Address:_____
(Street) *(City/State/Zip)*
Home Phone: (___)_____-_____ Cell Phone No.: (____)_____-_____
Race: _____ Ethnicity:_____ Preferred language:_____
E-mail Address:_____ Preferred Communication method: _____
Employer Name:_____ Employer Phone Number: (____)_____-_____
Employer Address: _____
(Street) *(City/State/Zip)*
Spouse's Name: _____ Spouse's Date of Birth: _____/_____/_____
Spouse's Employer:_____ Spouse's Employer Phone No.: ____/_____/_____
Spouse's Employer Address: _____
Primary Care Physician: _____

Person responsible for bill or parent (Complete only if different from patient)
Guarantor Name: _____Social Security No.: _____-_____-_____
Relationship to Patient: (please check) ( ) self, ( ) spouse, or (parent) Date of Birth: ____-____-____
Address:_____ Phone No.: (____)_____-_____
Employer Name: _____Employer Phone No.: (____)_____-_____
Employer Address:_____
(Street) *(City/State/Zip)*

Who to call in case of emergency (Not living in same household):
Name**: _____Address:_____**
Home Phone: (___)____-_____ Work Phone No.: (___)____-_____ Relationship:_____

Primary Insurance Information Co-pay Amount: $_____
Plan Name:_____ I.D. Number_____
Address: _____ Group No.: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security No. _____-_____-_____
Policy Holder's Date of Birth: _____-_____-_____ Sex: M / F

Secondary Insurance Information Co-pay Amount: $_____
Plan Name:_____ I.D. Number_____
Address: _____ Group No.: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security No. _____-_____-_____
Policy Holder's Date of Birth: _____-_____-_____ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y ___ N____
IF YES, PLESE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Shiloh Clinic, PLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____