Saint Francis Health System - LABORATORY

REGISTRATION

402-053 / 10-02

PLEASE PRINT

DATE

PATIENT INFORMATION

PRIMARY CARE PHYSICIAN	PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
DATE OF BIRTH	SEX ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Widowed ☐ Married ☐ Divorced
RELATIONSHIP TO GUARANTOR (IF OTHER THAN SELF, PLEASE FILL OUT GUARANTOR INFORMATION)	PREVIOUS NAME (IF CHANGED SINCE LAST VISIT)	
ADDRESS	CITY, STATE, ZIP CODE	
HOME TELEPHONE NUMBER ( )	E-MAIL (OPTIONAL)	FAX (OPTIONAL) ( )
EMPLOYER	WORK TELEPHONE NUMBER ( )	PAGER / CELL PHONE ( )
ADDRESS	CITY, STATE, ZIP CODE	

GUARANTOR INFORMATION (If patient is a minor)

RESPONSIBLE PARTY OR CUSTODIAL PARENT	GUARANTOR NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER
DATE OF BIRTH	SEX ☐ M ☐ F	RELATIONSHIP OF PATIENT TO GUARANTOR
HOME TELEPHONE NUMBER ( )		
ADDRESS	CITY, STATE, ZIP CODE	
EMPLOYER	WORK TELEPHONE NUMBER ( )	
ADDRESS	CITY, STATE, ZIP CODE	

EMERGENCY CONTACT

CONTACT NAME (PERSON NOT LIVING WITH YOU)	RELATIONSHIP
HOME TELEPHONE NUMBER ( )	WORK TELEPHONE NUMBER ( )

SPOUSE OR OTHER PARENT (If applicable)

NAME (LAST, FIRST, MIDDLE)	HOME TELEPHONE NUMBER ( )
ADDRESS (IF DIFFERENT THAN PATIENT)	CITY, STATE, ZIP CODE
EMPLOYER	WORK TELEPHONE NUMBER ( )

INSURANCE

PRIMARY INSURANCE COMPANY NAME	TELEPHONE NUMBER ( )		
ADDRESS	CITY, STATE, ZIP CODE		
GROUP NUMBER	CERTIFICATE / POLICY NUMBER	EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER (INSURED)
SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER		
SECONDARY INSURANCE COMPANY NAME	TELEPHONE NUMBER ( )		
ADDRESS	CITY, STATE, ZIP CODE		
GROUP NUMBER	CERTIFICATE / POLICY NUMBER	EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER (INSURED)
SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER		

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Saint Francis Health System on my behalf for any unpaid services rendered by the Saint Francis Health System Laboratory.

SIGNATURE	DATE

I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits.

SIGNATURE	DATE