REGISTRATION INFORMATION

Patient Name:______________________ M/F/Transgender__________ DOB____________

Address:__________________________ City______________ State________ Zip________

Home Phone:____________________ Cell Phone:______________ Email:________________

School:______________________ Grade________ Marital Status:________ Race:________

SS#:__________________ Religion:______________ Employer:____________________

Employer Phone:__________________ Stats: FT/PT/RETIRED

PARENT/GUARANTOR/GUARDIAN WHO WILL SIGN CONSENTS FOR TREATMENT:

Name:____________________ Relationship:______________________ DOB:__________

Address:__________________________ City______________ State________ Zip________

Home Phone:__________________ Cell Phone:______________ Work Phone:____________

Other Contact person (other parent/guardian or additional emergency contact): (Optional)

Contact:__________________________________ Relationship:____________________

Address:__________________________ City______________ State________ Zip________

Home Phone:__________________ Cell Phone:______________ Work Phone:____________

WHO CARRIES THE INSURANCE POLICY:

Name:____________________ DOB:__________ SS#:__________________________

Primary Insurance:________________________ ID#:____________________________

Relationship to patient:__________ Address (if different than patient)________________________

Policy holder's Employer:____________________ Employer phone:______________________

Position of Employment:______________________ Status: FT PT Retired Other

Secondary Insurance: Yes No

Name of secondary insurance: ________________________________ ID#:______________

Relationship to patient:____________ Address (if different than patient)______________________

Policy holder's employer:____________________ Employer phone:______________________

DOMINION HOSPITAL

Patient Information/Label

ADMIN DOM022 Rev 5/14