Saint Luke's Health System

Patient Registration Form

(Please complete as soon as possible and return in enclosed return envelope)

☐ Saint Luke's East ☐ Saint Luke's Hospital (Plaza) ☐ Saint Luke's North ☐ Saint Luke's South
☐ Saint Luke's Cushing ☐ Hedrick Medical Center ☐ Wright Memorial Hospital ☐ Anderson County Hospital

Date of Admission/Arrival/Service:	Time:
Referring Physician:	Family Physician:

SHADED AREA FOR HOSPITAL USE ONLY

Unit: Bed:	HIPAA given? Y N Date: ___/___/______	Hospital Consent signed? Y N Date: ___/___/______	Patient Class:
Chief Complaint:	Procedure/Test/Treatment:		Ins. Authorization #:
Accom. Code:	Service:	Level of care:	
Admitting Physician:	Attending Physician:		

Patient Information: Last Name	First Name	Middle	Previous Legal Names/Aliases:

Birth Date:	Age:	Social Security #:	Sex: M F	Email Address:

Street Address:	City:	State:	Zip:

Primary Phone: ( ) ☐ Home ☐ Work ☐ Cell	Alternate Phone: ( ) ☐ Home ☐ Work ☐ Cell	Place of Birth: US Citizen?:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Not Reported ☐ Other

Race: ☐ Caucasian/White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Declined ☐ Unavailable/Unknown

Preferred spoken language? ☐ English ☐ Other:____________________
Would you like an interpreter? ☐ Yes ☐ No ☐ Declined

Preferred written language:
☐ English ☐ Other:__________________

Have you ever been treated at a Saint Luke's facility? ☐ Yes (which facility?______________________________) ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Education Level: ☐ 8th Grade or Less ☐ Some High School ☐ High School Diploma/GED ☐ Some College/2-Year Degree
☐ 4-Year College Degree ☐ Declined ☐ Unavailable/Unknown ☐ > 4-Year College Degree

Do you have an Advance Directive? ☐ Yes ☐ No
☐ Living Will ☐ Durable Power of Attorney (name:______________________) ☐ Healthcare Proxy

Religious Preference:	If Pregnant, date of last menstrual period:

Guarantor Information: ☐ Same as Patient	Name	Relationship to patient:	DOB:

Street Address	City	State	Zip

Primary Phone ( ) ☐ Home ☐ Work ☐ Cell	Alternate Phone ( ) ☐ Home ☐ Work ☐ Cell	SSN

Name of Employer:	Employment Status: ☐ Part-Time ☐ Full-Time ☐ Retired (Date __/__/____) ☐ Disabled ☐ Student (PT or FT) ☐ Not Employed ☐ Active Duty ☐ Self-Employed ☐ Unknown

Emergency Contact: ***If patient is a dependent child, emergency contact must be the child's legal guardian***
☐ Demographic information is same as patient

Name	Relationship to Patient	Legal Guardian: Y N

Street Address	City	State	Zip

Primary Phone ( ) ☐ Home ☐ Work ☐ Cell	Alternate Phone ( ) ☐ Home ☐ Work ☐ Cell	Notify on admission: Y N

ATTACH CLEAN COPIES OF BOTH SIDES OF INSURANCE CARDS & REFERRAL FORM

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Insurance Information

LIST NAMES AS THEY APPEAR ON INSURANCE CARDS

Patient (member's) Name______________________________________ ☐ Self-Pay ☐ Do Not Bill Insurance

If no insurance, skip to Accident Information Section

INSURANCE INFORMATION: ______Primary ______Secondary ☐ Medicaid (Skip to line 6) ☐ Medicare (Skip to line 6)

1. Insurance Company: ______________________________
2. Billing Address: ______________________________
3. Customer Service Phone:(____________)______________________________
4. **Subscriber's Information *(if different from patient)*:** ☐ Patient is subscriber
   Name on card:__________________________ Subscriber's Birth Date:__________________________
   Relationship to Patient: __________________________ SSN:__________________________
5. Group Name (Employer): __________________________ Group Number: __________________________
6. Policy ID/Medicaid Number:______________________________
7. Claim Number (if Applicable):______________________________

INSURANCE INFORMATION: ______Primary ______Secondary

1. Insurance Company: ______________________________
2. Billing Address: ______________________________
3. Customer Service Phone:(____________)______________________________
4. **Subscriber's Information *(if different from patient)*:** ☐ Patient is subscriber
   Name on card:__________________________ Subscriber's Birth Date:__________________________
   Relationship to Patient: __________________________ SSN:__________________________
5. Group Name (Employer): __________________________ Group Number: __________________________
6. Policy ID/Medicaid Number:______________________________
7. Claim Number (if Applicable):______________________________

ACCIDENT INFORMATION:

Is Condition the Result of an Accident: ☐ Yes ☐ No Work Related: ☐ Yes ☐ No

If Yes, Please Provide the Following Accident Information:

Accident Place (Where):______________________________

Accident Nature (What):______________________________

Accident Date:__________________ Time:__________________

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