SENTARA

Sentara Medical Group

Patient Registration Form

Last Name_____ First Name_____ MI____

AKA (Also Known As) /Previous Last Name(s)_____

Social Security #_____-_____-_____ Date of Birth_____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ___Married ___Single ___Divorced ___Legally Separated ___Widowed ____ Life Partner

Home Address _____

_____

City_____ State_____ Zip Code_____

Home Phone(_____)_____ Cell Phone(_____)_____

Alternate Phone(_____)_____ Alternate Phone Info _____

E-Mail_____

Patient/Family Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Alt Phone ☐ E-Mail ☐ Text Primary Care

Physician/Pediatrician _____

If pediatric patient, please list siblings _____

_____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Pacific Islander or Native Hawaiian ☐ Other Race – Please Print _____

Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

☐ Other/Unknown – Please Print if Other _____

Language Preference: If other than English- Please Print_____

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication?

If yes, Please check appropriate item(s): ☐ Vision ☐ Hearing

Patient's Employer_____

Address_____

City_____ State_____ Zip Code_____

Work Phone Number(_____)_____ Ext_____

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients ☐ Guarantor? ☐ Legal Guardian?

Guarantor/Legal Guardian Name_____ Social Security #_____-_____-_____

Patient's Relationship to Guarantor/Legal Guardian: ☐ Spouse ☐ Dependent Child ☐ Student

Date of Birth _____/_____/_____ ☐ Other – Please Print _____

Guarantor/Legal Guardian Home Address _____

_____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

Guarantor/Legal Guardian Employer Name & Address _____

_____

City _____ State _____ Zip Code _____

Emergency Contact - Who to call in the event of an Emergency

1. Name _____ Relationship _____

   Cell/Hm Phone #(_____) _____ Work Phone #(_____) _____

2. Name _____ Relationship _____

   Cell/ Hm Phone #(_____) _____ Work Phone #(_____) _____

Is your visit due to a job related injury or automobile accident? ☐ Yes ☐ No

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) ☐ Yes ☐ No

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Does the patient have insurance? ☐ Yes ☐ No

Primary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Primary Insurance***

Plan Name _____

Policy Holder's Name _____ Gender: ☐ Male ☐ Female

Policy Holder's # _____ - _____ - _____ Policy Holder's Date of Birth ____/____/____

Secondary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Secondary Insurance***

Plan Name _____

Policy Holder's Name _____ Gender: ☐ Male ☐ Female

Policy Holder's # _____ - _____ - _____ Policy Holder's Date of Birth ____/____/____

Patient/Guarantor Printed Name _____

Patient/Guarantor Signature _____ **Date** ____/____/____