[Patient Label]

SENECA HEALTHCARE DISTRICT

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

FULL NAME _____
First Middle Last Preferred Name

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

BIRTH SEX ☐ Male ☐ Female
The sex assigned at birth on the birth certificate

ADMINISTRATIVE SEX ☐ Male ☐ Female
Is used for administrative purposes such as insurance billing

PHYSICAL ADDRESS _____
Street **City** **State** **Zip Code**

MAILING ADDRESS _____
Street **City** **State** **Zip Code**

PHONE
Select Preferred
☐ Home ☐ Cell ☐ Other

RACE (choose up to five)
- ☐ **American Indian or Alaska Native**
- ☐ **Asian**
- ☐ **Black or African American**
- ☐ **Native Hawaiian or Other Pacific Islander**
- ☐ **White**
- ☐ **Any other race not covered above**
- ☐ **Decline to state**

ETHNICITY
- ☐ **Hispanic or Latino**
- ☐ **Non-Hispanic or Latino**
- ☐ **Decline to state**

MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MAIDEN LAST NAME _____

PREFERRED LANGUAGE **RELIGION** **MILITARY** ☐ Yes ☐ No

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME _____ **PHONE** _____

ADDRESS _____
Street City State Zip Code

EMPLOYMENT INFORMATION

EMPLOYER NAME _____ **PHONE** _____

ADDRESS _____
Street City State Zip Code

SPOUSE EMPLOYER NAME _____ **PHONE** _____

ADDRESS _____
Street City State Zip Code

RETIREMENT DATES

PATIENT RETIREMENT DATE	**SPOUSE RETIREMENT DATE**

[Patient Label]

PATIENT REGISTRATION FORM

EMERGENCY CONTACT(S) INFORMATION AND RELATIONSHIP TO PATIENT

PRIMARY

NAME _____ **RELATIONSHIP TO PATIENT** _____

PHONE _____
Select Preferred

□ Home □ Cell □ Other

ADDRESS _____
Street City State Zip Code

SECONDARY

NAME _____ **RELATIONSHIP TO PATIENT** _____

PHONE _____
Select Preferred

□ Home □ Cell □ Other

ADDRESS _____
Street City State Zip Code

NEXT OF KIN

NAME _____ **RELATIONSHIP TO PATIENT** _____

PHONE _____
Select Preferred

□ Home □ Cell □ Other

ADDRESS _____
Street City State Zip Code

NATIONAL HEALTH INFORMATION EXCHANGE

The nationwide network of electronic health information which provides other healthcare facilities access to your pertinent health information, such as medications, allergies, and illness diagnosis; in the event of an emergency so the provider may provide the appropriate care to save your life. Do you accept/decline for us to send your information?

PARTICIPATION □ I Accept □ I Decline

HEALTHELIFE ENROLLMENT AKA: MYSENECA

CERNER's electronic records application that is available online or downloadable to your phone through Google Play or iTunes. The application is free and will link the patient to their available electronic health record through Seneca Healthcare District.

PARTICIPATION Would you like to have access to your electronic health records from Seneca Healthcare District through HealtheLife?"

□ Yes **EMAIL ADDRESS**

□ No

[Patient Label]

SENECA HEALTHCARE DISTRICT

PATIENT REGISTRATION FORM

FINANCIAL INFORMATION

GUARANTOR IF NOT THE PATIENT (FINANCIALLY RESPONSIBLE PARTY FOR MINOR OR INCAPACITATED ADULT):

NAME _____ **DATE OF BIRTH** _____

GENDER □ Male □ Female **SSN** _____

PHONE _____
Select Preferred □ Home □ Cell □ Other

INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE

INSURANCE CARRIER _____

SUBSCRIBER NAME _____
First Middle Last

SUBSCRIBER DATE OF BIRTH _____ **SUBSCRIBER ID#** _____

GROUP NUMBER _____ **CARRIER CUSTOMER PHONE** _____

RELATIONSHIP TO SUBSCRIBER □ Self □ Child □ Adopted Child
□ Spouse □ Partner □ Other_____

CLAIMS ADDRESS _____
Street City State Zip Code

SUBSCRIBER'S EMPLOYER **EMPLOYER PHONE**

SECONDARY HEALTH INSURANCE

INSURANCE CARRIER _____

SUBSCRIBER NAME _____
First Middle Last

SUBSCRIBER DATE OF BIRTH _____ **SUBSCRIBER ID#** _____

GROUP NUMBER _____ **CARRIER CUSTOMER PHONE** _____

RELATIONSHIP TO SUBSCRIBER □ Self □ Child □ Adopted Child
□ Spouse □ Partner □ Other_____

CLAIMS ADDRESS _____
Street City State Zip Code

SUBSCRIBER'S EMPLOYER **EMPLOYER PHONE**

TERTIARY HEALTH INSURANCE

INSURANCE CARRIER _____

SUBSCRIBER NAME _____
First Middle Last

SUBSCRIBER DATE OF BIRTH _____ **SUBSCRIBER ID#** _____

GROUP NUMBER _____ **CARRIER CUSTOMER PHONE** _____

RELATIONSHIP TO SUBSCRIBER □ Self □ Child □ Adopted Child
□ Spouse □ Partner □ Other_____

CLAIMS ADDRESS _____
Street City State Zip Code

□ No Health Insurance □ Worker's Comp. □ Auto Insurance □ Other _____