



Patient Registration Form

Please print clearly your response to all requested information. If you have questions, please ask. THANK YOU!!!

Where did you hear about Tri-Area Health Clinic?
College
Community Event
Family/Friend
Health Dept/Social Services/Free Clinic
Newspaper
Television
Other

Patient Information

Patient's Full Name: (FIRST) (MIDDLE) (LAST)

Address: (STREET) (CITY) (STATE) (ZIP)

Home Phone: ( ) - Work: ( ) - DOB: / / (mm/dd/yyyy)

Email Address: Race: Are you a veteran? (circle one) Yes No

Social Security #: / / Marital Status: (circle one) S M D W (Single/Married/Divorced/Widowed) Age:

Employer: Phone No: ( ) -

Employer's Address: (STREET) (CITY) (STATE) (ZIP)

Responsible Party Information

Name: (FIRST) (MIDDLE) (LAST)

Physical Address: (STREET) (CITY) (STATE) (ZIP)

Mailing Address: (STREET) (CITY) (STATE) (ZIP)

Home Phone: ( ) - Work: ( ) - DOB: / / (mm/dd/yyyy)

Employer: Phone No: ( ) -

Employer's Address: (STREET) (CITY) (STATE) (ZIP)

Insurance Information

Who is the insurance policy holder?: (circle one) Self Spouse Parent - Mother or Father

Name of Policy Holder: (FIRST) (MIDDLE) (LAST)

Social Security # or Policy ID#: Policy Holder DOB:

Policy Holder's Employer: Phone: ( ) -

Employer's Address: (STREET) (CITY) (STATE) (ZIP)

Emergency Contact

Emergency contact other than spouse: (FIRST) (MIDDLE) (LAST) Relationship to you:

Emergency Contact Address: (STREET) (CITY) (STATE) (ZIP)

Home Phone: ( ) - Work Phone: ( ) -

With your permission, what is your preferred method of contact regarding your medical care?

I HEREBY AUTHORIZE THE FOLLOWING:

- Tri-Area Community Health through its appropriate personnel and/or its medical staff to perform, administer, prescribe, or to have performed, administered, or prescribed upon, to, or for me or any members of my family...
Insurance Authorization and Assignment to furnish information to insurance carriers concerning my illness and treatments...
Medicare Lifetime Authorization for physical services and request that payment of authorized Medicare benefits...
Deemed Consent for Designated Blood borne Pathogens: Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing...
I ALSO CERTIFY that I have read and understand the collection policy of Tri-Area Community Health and agree to abide by it.

THE INFORMATION PROVIDED ON THIS REGISTRATION FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: DATE:

WITNESS: DATE: