



PATIENT REGISTRATION

Name: [ ] Last First MI DOB: [ ] Sex: [ ] Marital Status: [ ]

Mailing Address: [ ] Street City State Zip Code

Street Address: [ ] Email Address: [ ]

Home Phone: [ ] Cell Phone: [ ] Work Phone: [ ] Drivers License #: [ ] State: [ ]

Social Security #: [ ] Employer: [ ]

Employer's Address: [ ] Occupation: [ ]

Spouse/Parent/Responsible Party: [ ] DOB: [ ] SSN: [ ]

Mailing Address: [ ]

Home Phone: [ ] Cell Phone: [ ] Work Phone: [ ] Street City State Zip Code

Employer: [ ] Employer's Address: [ ]

INSURANCE INFORMATION

Primary Insurance (or Workman's Comp carrier): [ ]

Subscriber Name: [ ] DOB: [ ] SSN: [ ]

Subscriber ID#: [ ] Group#: [ ]

Secondary Insurance (if applicable): [ ]

Subscriber Name: [ ] DOB: [ ] SSN: [ ]

Subscriber ID#: [ ] Group#: [ ]

Emergency Contact: [ ] Relationship: [ ] Phone #: [ ]

Right to Privacy: May we share your health information with your spouse or a designated party? If yes, complete below:

Name: [ ] Relationship: [ ] Phone #: [ ]

Referred by: Hospital: [ ] Doctor: [ ] Other: [ ]

Accident/Injury Information: Work/Auto? [ ] What State? [ ] Date of Injury [ ] Is there an attorney? [ ]

Attorney's Name: [ ] How did it happen? [ ]

I verify that the above information is true and correct and that I will keep AkHES informed of any changes in the above.

\*Signature (responsible party): [ ] Date: [ ]

\*Signatures on this page expire one year from date signed. A new signature is required yearly. By typing your name in this area you are stating the above information is true and correct to the best of your knowledge and this electronic form of signature will be treated the same as your original signature.