765-768-6065 (PH)

Meridian Health Services

PATIENT REGISTRATION FORM

□ New Registration □ Updated Registration □ Reason for Change (NAME ONLY):_____

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Date of Birth:	□ MALE □ FEMALE	
Street Address:		
City:	State:	Zip Code:
Primary / Home Phone:	Other / Cell Phone:	
Homeless: □ Homeless Shelter □ Transitional □ Doubling Up □ Street □ Other □ Unknown		
Email Address:	Permission to Use Email Address: □ Yes □ No	
Marital Status: □ Married □ Divorced □ Single □ Life Partner □ Widowed □ Legally Separated □ Unknown		
Social Security Number (Optional):		
Primary Language: □ English □ Spanish □ Japanese		
Patient Ethnicity: □ Hispanic/Latino □ Unreported/Refused □ Non-Hispanic/Latino		
Veteran □ Yes □ No		
Employer:		
Street Address:		
City:	State:	Zip Code:
Phone:	Direct Extension:	
Occupation:	Shift: 1st 2nd 3rd	
Migratory/Seasonal: □ Migratory Worker □ Seasonal Worker □ Refused □ Not Available		
Employment Status: □ Full Time □ Part Time □ Unemployed □ Active Military Duty □ Self Employed □ Retired □ Unknown		

CONTACT INFORMATION

Next of Kin (Relative):

Last Name:	First Name:	Middle Initial:
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Relationship to Patient:		

Person to Notify / Emergency Contact:

Last Name:	First Name:	Middle Initial:
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Relationship to Patient:		

PATIENT LABEL

RESPONSIBLE PARTY / GUARANTOR

Last Name:	First Name:	Middle Initial:	Date of Birth:
Street Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Social Security Number (Optional):			
Relationship to Patient:			
Guarantor Employer:			
Street Address:			
City:	State:	Zip Code:	
Phone:	Direct Extension:		
Occupation:	Shift: 1st 2nd 3rd		
Employment Status: ☐ Active Military Duty	☐ Full Time ☐ Self Employed	☐ Part Time ☐ Retired	☐ Unemployed ☐ Unknown

INSURANCE INFORMATION

PRIMARY Insurance Name:	Policy Number:	Group Number:
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Middle Initial:
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Social Security Number (Optional):		
Relationship to Patient:		
SECONDARY Insurance Name:	Policy Number:	Group Number:
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Middle Initial:
Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Social Security Number (Optional):		
Relationship to Patient:		

AUTHORIZATION

In order for Meridian Health Services to provide healthcare to me, I understand and authorize the following:

- Release of information to hospitals, specialists, physicians, or nurse practitioners providing on-call services to Meridian Health Services, and to other healthcare providers that may be consulted in the provision of healthcare to me. This may include, but is not limited to, Jay County Hospital providers.
- There may be times when the physicians, nurse practitioners, or staff members will need to contact me regarding appointments, test results, or other communications. You may contact me or leave a message at any given numbers above.

PATIENT (OR RESPONSIBLE PARTY) SIGNATURE DATE