Hendricks Regional Health

Hendricks Regional Health Medical Group
Adult Patient Registration

Please Print Clearly

Date_____

Physician _____

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code_____

Home Phone_____

Cell Phone Number _____

Work Phone Number _____

Date of Birth _____ Male ☐ Female ☐

Single ☐ Married ☐ SSN_____

Name of Employer_____

Emergency Contact _____
(**NOT** living with you)

Emergency Contact phone _____

Relationship to Emergency Contact _____

Primary Insurance _____

Secondary Insurance_____

Local Pharmacy _____
(Please list name and location)

Mail-In Pharmacy _____

Email address _____

Responsible Party (person who will receive statements)

Name_____

Address _____

City _____

State _____ Zip Code _____

Spouse Information

Name_____

Cell Phone Number _____

Work Phone Number _____

Insured Information
(only provide if other than patient)

Primary Ins: Insured Name _____

Date of Birth _____ SSN _____

Relationship to Patient _____

Secondary Ins: Insured Name _____

Date of Birth _____ SSN _____

Relationship to Patient _____

Additional Information

Race _____

Ethnicity _____
(Options: Hispanic, Non-Hispanic, Refuse to report)

Language _____

Hendricks
Regional Health

At Hendricks Regional Health we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted speak to at any time by completing a new form.

I authorize Hendricks Regional Health Medical Group physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

_____ _____
Signature Date

_____ _____
Patient Printed Name Date of Birth

_____
Witness