Brookwood Baptist Health.

Patient Registration Form

Date: _____ Doctor: _____

Reason for Visit: _____

PATIENT INFORMATION					
Name (Last, First, Middle)		Preferred Name	Social Security Number	Date of Birth	
Home Address		City/ State	Zip Code	Driver's License #	
Email Address		Home Phone #	Cell Phone#		
Sex ☐ Male ☐ Female	Sexual Orientation	Gender Identity	Assigned Sex at Birth	Pronoun ☐ He ☐ She ☐ They	
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced		Ethnicity ☐ Hispanic ☐ Other ☐ Not Reported			
Race ☐ Caucasian	☐ African American	☐ Hispanic	☐ Asian	☐ American Indian	☐ Other
Primary Language ☐ English	☐ Spanish	☐ French	☐ Japanese	☐ Chinese	☐ Other
Emergency Contact	Relationship	Phone			
Employer	Address	Phone			
Pharmacy	Address	Phone			

RESPONSIBLE PARTY/GUARANTOR INFORMATION (IF DIFFERENT THAN ABOVE – PERSON TO WHOM STATEMENT IS SENT)				
Name (Last, First, Middle)	Social Security Number	Date of Birth	Age	Sex
Local Address	City, State, Zip	Secondary Billing Address (if applicable)		
Home Phone #	Cell Phone #	Relationship to Patient		

PRIMARY INSURANCE			
Name of Insurance Company	Address (Street, City, St, Zip)		Copay
Policy Holder Name	Social Security Number of Policy Holder	DOB	
Contract #	Group #	Effective Date	

SECONDARY INSURANCE (IF APPLICABLE)			
Name of Insurance Company	Address (Street, City, St, Zip)		Copay
Policy Holder Name	Social Security Number of Policy Holder	DOB	
Contract #	Group #	Effective Date	

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)

☐ Television	☐ Event	☐ Signage	☐ Rating Website (Vitals, HealthGrades, etc.)	☐ Word of Mouth
☐ Radio	☐ Zoc Doc	☐ Physician Referral	☐ Search Engine (Google, Yahoo, etc.)	☐ Brookwood Medical Center Website
☐ Billboard	☐ Mailer	☐ Social Media	☐ Magazine/Newspaper Ad	☐ Brookwood Care Network Website

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WORKER'S COMPENSATION		
Is this a Workman's Compensation Case? (If yes, please provide the following information) □ Yes □ No	Employer	Date of Injury
Work Comp Carrier	Address	Phone Number
Work Comp Case Manager	Work Comp Case Number	Effective Dates
LIST ANY OTHER PHYSICIAN OR PROVIDER THAT YOU WOULD LIKE TO RECEIVE A COPY OF YOUR REPORT		
Physician	Address	Phone Number
Physician	Address	Phone Number
Coach/Trainer	Address	Phone Number

To the best of my knowledge the above information is complete and accurate.

Signature of Patient/Guardian: _____ **Date:**_____