Johnson County Hospital Patient Registration Form

Patient Information

Name Last:		First:	MI:
Sex: Male Female		Pt Address	
Date of Birth		Pt City/State	
		Pt Zip	
Pt Primary Dr		Pt Phone	Pt Cell Phone
Pt Race		Pt's Employer Name	
Pt Marital Status S M D W		Employer Address	
Pt Social Security #		Employer City/State	
		Employer Zip	
Religious Preference:		Pt Work Phone	
Emergency Contact:		Address (if different from pt)	
		City/State	
Relationship to Pt:		Zip	
Home Phone	Cell Phone	Work Phone	

REASON FOR VISIT:

☐ **INJURY**	Where?	Date of Injury?	Time of Injury?
☐ **WORKCOMP**	Where?	Date of Injury?	Time of Injury?
☐ **ACCIDENT**	Where?	Date of Injury?	Time of Injury?
☐ **MVA***	Where?	Date of Injury?	Time of Injury?
☐ **OTHER**	Where?	Date of Injury?	Time of Injury?

*Get copy of Auto Insurance

Guarantor Information (Person Responsible for the Bill)

Guar Name Last:		First:	MI:
Guar Sex Male Female			
Guar Date of Birth		Guar Social Security #	
Guar Address		Guar Employer Name	
Guar City/State		Guar Employer Address	
Guar Zip		Guar Employer City/State	
Guar Home Phone		Guar Employer Zip	
Guar Marital Status S M D W		Guar Work Phone	

Insurance Information (Need copy of insurance card - front & back)

Primary Insurance	Secondary Insurance:
Name of Policy Holder (if different than Pt)	
DOB:	**Do you have Medicare?**
SSN:	
Employer Name	**Do you have Medicaid?**
Employer Address	
Employer City/State	**Do you have Blue Cross/Blue Shield?**
Employer Zip	
Employer Work Phone	**Do you have VA?**