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| --- |
| **PATIENT INFORMATION:** |
| Last Name: | First Name: |
| Middle Name: | Maiden/Other: |
| Birthdate: | Sex: [ ]  M [ ]  F | Social Security Number: |
| Home Phone: | Cell Phone: | Other Phone: |
| Address: | City: | State: | Zip: |
| Have you ever registered at any EH facility under any other name? | [ ]  Yes [ ]  No | What Name? |
| Employer: | Occupation: | Employer’s Phone: |
| Employer’s Address: | City: | State: | Zip: |
| **PERSON TO NOTIFY** (In Case of Emergency) |
| Name: | Relationship: | Phone: |
| Address: | City: | State: | Zip: |
| **PERSON ULTIMATELY RESPONSIBLE FOR BILL IF DIFFERENT FROM PATIENT** (Guarantor/Responsible Party) |
| Name: | Relationship: | Phone: |
| Address: | City: | State: | Zip: |
| **PRIMARY INSURANCE** |
| Insurance Company Name: | Insurance ID #: | Group #: |
| Policy Holders Last Name: | First Name: | Middle Name: |
| Birthdate: |
| **SECONDARY INSURANCE**  |
| Insurance Company Name: | Insurance ID #: | Group #: |
| Policy Holders Last Name: | First Name: | Middle Name: |
| Birthdate: |

**Essentia Health**

**Registration Form**