REGISTRATION FORM

(Please Print)

LITTLETON REGIONAL HEALTHCARE

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email Address:	Cell phone no: ( )	Work phone no.: ( )

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

ADDITIONAL INFORMATION

Preferred Local Pharmacy: Address: City:	Other Preferred Mail Order Pharmacy: Address: City:

Would you like to sign up for the web Patient Portal so you can view your Lab results? ☐ Yes ☐ No

We are now required by CMS to collect information on race and ethnicity. How do you want to be listed?	☐ American Indian or Native Alaskan	☐ Asian	☐ Black or African American	☐ White	☐ Hispanic

☐ Decline to State	☐ Native Hawaiian			☐ Other

Any Special Needs?

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Littleton Regional Healthcare, my physician, or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*