Randolph Health Medical Group

Today's Date _____ Patient Number _____ Injury Date _____

Patient Information

Name _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Physical Address _____
(if differs from above) Street City State Zip

Telephone Number (___)_____ Cell Phone Number (___)_____ Email Address _____

Date of Birth _____ Social Security Number _____
mm/dd/year

(Circle One)

Sex: Male Female Status: Minor Single Married Separated Divorced Widowed

Race: White Black Asian Alaskan Native American Indian Other _____

Hispanic Ethnicity: Yes No Primary Language _____

Employer _____ Phone Number (___)_____

Address _____
Street City State Zip

Emergency Contact: Name _____ Telephone Number (___)_____

How did you hear about us? □ Friend □ Internet □ Newspaper □ Phonebook □ Referral Physician □Randolph Hospital ER
□ Other _____

Person Responsible for Bills (Guarantor) ***Please complete this section if other than self***

Name _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Telephone Number (___)_____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____
mm/dd/year

Alternate Emergency Contact Information (Other than Household Member or Self)

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

Telephone Number (___)_____ Relationship to Patient _____

Please continue on back side

Patient Name _____ Patient DOB _____

If Patient is a Child

Father's FULL NAME & Address _____

Employer Name & Address _____

Mother's FULL NAME & Address _____

Employer Name & Address _____

Insurance Information

(1) Primary Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer _____
(as listed on card)

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

••••••••••••••••••••••••••••••••••••

(2) Secondary Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer _____
(as listed on card)

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

••••••••••••••••••••••••••••••••••••

Workman's Compensation

If the injury occurred on the job, please provide information below for worker's compensation.

Date of Injury _____

Name and Location of Employer _____

Details of how the injury occurred _____

_____

_____