Huntington Health Physicians

Patient Registration

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Name ______________________

Address ______________________

City/State/Zip ______________________

Social Security Number ______________________

Date of Birth __________

Circle gender: Female Male

Phone (Home) ______________________

Phone (Cell) ______________________

Phone (Work) ______________________

Occupation/Student ______________________

Employer/School ______________________

Referred by ______________________

Parent / Spouse Information

(Complete only if patient is a minor, or if spouse is insurance holder)

Name ______________________

Address ______________________

City/State/Zip ______________________

Date of Birth ______________________

Phone (Home) ______________________

Phone (Cell) ______________________

Phone (Work) ______________________

Relationship to Patient:

❑ Husband ❑ Wife ❑ Father ❑ Mother ❑ Friend
❑ Step-Father ❑ Step-Mother ❑ Legal Guardian

Parent / Spouse Information

(Complete only if patient is a minor, or if spouse is insurance holder)

Name ______________________

Address ______________________

City/State/Zip ______________________

Date of Birth ______________________

Phone (Home) ______________________

Phone (Cell) ______________________

Phone (Work) ______________________

Relationship to Patient:

❑ Husband ❑ Wife ❑ Father ❑ Mother ❑ Friend
❑ Step-Father ❑ Step-Mother ❑ Legal Guardian

Emergency Contact Łyƒ2ǊYl-ǘ2y

Name: ______________________

Phone (Home): ______________________

Phone (Cell): ______________________

Phone (Work): ______________________

Relationship to Patient:

❑ Husband ❑ Wife ❑ Father ❑ Mother ❑ Friend
❑ Step-Father ❑ Step-Mother ❑ Legal Guardian

Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from a Huntington Health Physicians office and to make and receive phone calls regarding my health and or the billing related to the services provided to me by Huntington Health Physicians.

❑ Spouse (Name): ______________________

❑ Caregiver (Name): ______________________

❑ Child (Name): ______________________

❑ Other (Name): ______________________

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Signature of Patient or Representative Today's Date