ST. JOSEPH MERCY OAKLAND
A MEMBER OF TRINITY HEALTH

PATIENT REGISTRATION FORM

FILL OUT FORM COMPLETELY

PATIENT INFORMATION

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	AGE	BIRTHDATE	SEX M F	MARITAL STATUS S M W D

ADDRESS	CITY	STATE	ZIP	PHONE

EMPLOYER (PATIENT OR PARENT)	DAY TIME PHONE /CELL	REFERRING/PRIVATE PHYSICIAN

RELATIVE OR FRIEND TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING AT PATIENT=S RESIDENCE)	RELATIONSHIP TO PATIENT	PHONE

INSURANCE INFORMATION

NAME OF INSURANCE HOLDER	RELATIONSHIP TO PATIENT	BIRTHDATE	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

EMPLOYER NAME AND ADDRESS	CITY	STATE	ZIP	PHONE

NAME OF INSURANCE

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO If yes, complete the following

NAME OF INSURANCE HOLDER	RELATIONSHIP TO PATIENT	BIRTHDATE	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

EMPLOYER NAME AND ADDRESS	CITY	STATE	ZIP	PHONE

NAME OF INSURANCE

How did you learn about this facility?

Family	Drive By	Direct Mail	Yellow Pages
Friend	Doctor Referred	Advertisement	Employed with Mercy Organization
Ask-a-Nurse	Employer	HMO	Other _____

AUTHORIZATION: I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any, including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any, and records of a communicable disease, if any; to my insurance company(s) for the purpose of payment of bill and to my health care provider for continuity of care. I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance.

I understand that if any employee, physician, or agent of SJMH-O sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I HEREBY CERTIFY THAT THE CONTENTS OF THIS FORM ARE UNDERSTOOD BY ME. PARAGRAPHS OR LINES THAT I CHOOSE NOT TO PERTAIN TO ME, IF ANY, WERE STRICKEN BEFORE I SIGNED:

_____ _____ _____

Signature Date (valid for one year) Witnessing Signature Only

Please bring this form to the receptionist along with your Drivers License and Insurance I.D. Card.
Your insurance will be billed for those services that are covered benefits.

Thank You

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.