Horizon Healthcare
An Affiliate of
Fairfield Memorial Hospital Association

PATIENT REGISTRATION FORM

213 NW 10th, Ste A
Fairfield, IL 62837
Ph 842-4617 Fax 842-4743

PLEASE PROVIDE DRIVER'S LICENSE AND INSURANCE CARDS FOR COPY.

PATIENT INFORMATION:

Legal Name: _____ Maiden Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone Number: _____ Cell: _____ Day: _____

Alternate: _____ Work: _____ Email Address: _____

(*We will not share this with other entities or send confidential information via email.*)

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American **Ethnicity** ☐ Hispanic or Latino
☐Native Hawaiian or Pacific Islander ☐ White ☐ Other _____ ☐ Non-Hispanic or Latino

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Minor ☐ Separated

Employer: _____ Employer's Phone: _____

City: _____ St: _____ Zip: _____

RESPONSIBLE PARTY (GUARANTOR) FOR CHARGES NOT PAID BY INSURANCE:

Guarantor's Name: _____ Relationship to patient: _____

SS #: _____ Date of Birth: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Employer: _____

Address: _____ City/St: _____ Zip: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American **Ethnicity** ☐ Hispanic or Latino
☐Native Hawaiian or Pacific Islander ☐ White ☐ Other _____ ☐ Non-Hispanic or Latino

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other

Emergency Contact: Name:_____ **Relationship:**_____ **Phone:**_____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name: _____	Insurance Name: _____
Policyholder: _____	Policyholder: _____
Date of Birth: _____ SS#: _____	Date of Birth: _____ SS#: _____
Address: _____	Address: _____
City/St/Zip: _____	City/St/Zip: _____
Employer: _____	Employer: _____
Relationship to Patient: _____	Relationship to Patient: _____
Effective Date of Coverage: _____	Effective Date of Coverage: _____
Race:	Race:
☐ American Indian or Alaska Native ☐ Asian	☐ American Indian or Alaska Native ☐ Asian
☐ White ☐ Black or African American	☐ White ☐ Black or African American
☐Native Hawaiian or Pacific Islander	☐Native Hawaiian or Pacific Islander
Other _____	Other _____
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	**Ethnicity** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Preferred Language:	Preferred Language:
☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other	☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other

If any of the information above changes, please notify us in a timely manner. If patient is unable to sign and you are Healthcare Power of Attorney or Legal Guardian, you must provide us with legal documentation for our records. If applicable, please provide us with a copy of Advanced Directives as well.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

Who can we thank for your referral? _____

REV 3-2013