Horizon Healthcare
An Affiliate of
Fairfield Memorial Hospital

PATIENT REGISTRATION FORM

213 NW 10th Street, Suite A
Fairfield, IL 62837
Ph 618-8424617
Fax 618-842-4743

Please present Driver's License & Insurance Cards for Copy

PATIENT INFORMATION:

Legal Name ______________________________ Maiden Name ______________
FIRST MIDDLE LAST

Social Security Number ______________ Date of Birth ____________ Age: _____ ◯ Male ◯ Female

Address ______________________________ City ______________ St ____ Zip __________

◯ Home Phone ______________ ◯ Cell Phone ______________ ◯ Work Phone ______________

(Please check your preferred phone)

Email Address: ______________________________ (***we will not share this with other entities***)

Preferred Language:
__ English __Spanish __French __Chinese __Other

Ethnicity:
__Hispanic or Latino __Non-Hispanic or Latino

Religious Preference ______________ (if none, please write N/A) **Race:** ______________

Marital Status
__Single __Married __Domestic Partner __Life Partner __Divorced __Separated __Widow __Minor

Do you have any Advanced Directives: __Yes __No **If 'Yes', please provide us with a copy of Advanced Directives.**

Do you have any hearing or vision impairment: __No __Yes, hearing __Yes, vision Explain: ______________

EMPLOYER: ______________________________

GUARANTOR INFORMATION: (*Complete this section if patient is a minor, or if someone other than patient is responsible for charges not paid by insurance*)

◯ **Same as patient**

Guarantor's name ______________________ Relationship to Patient ______________

Guarantor's Phone #: ______________ Guarantor's Date of Birth: __________ SS #: ______________

Address: ______________________________ City ______________ St _____ Zip __________

◯ ***Check here if address is same as patient***

EMERGENCY CONTACT FOR PATIENT:

Name: ______________________ Relationship:______________ Phone: ______________

Secondary Contact/Support Role: Name ______________ Relationship______________ Phone______________

IF PATIENT IS A MINOR, HAVE YOU COMPLETED A "WHEN YOU'RE NOT THERE" FORM? ***__YES __ NO***

If NO, please ask your customer service representative for a form.

Primary Insurance	Secondary Insurance
Insurance Company Name: ______________	Insurance Company Name: ______________
Policyholder's Name: ______________	Policyholder's Name: ______________
Policyholder's Date of Birth: ________ SS#: __________	Policyholder's Date of Birth: ________ SS#: __________
Address: ______________	Address: ______________
City: ______________ State: ______ Zip: ________	City: ______________ State: ______ Zip: ________
Employer: ______________	Employer: ______________
Relationship to Patient: ______________	Relationship to Patient: ______________
Effective Date of Coverage: ______________	Effective Date of Coverage: ______________
◯ ***SAME AS PATIENT***	◯ ***SAME AS PATIENT***
◯ ***SAME AS GUARANTOR***	◯ ***SAME AS GUARANTOR***

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: ______________________________