REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Physician:		

PATIENT INFORMATION

Patient's last name: First: Middle:			Tobacco User: ❑ Yes ❑ No	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Home phone no.: ( )	Cell phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			
Social Security #:	Drivers License #:	Race: ❑ White ❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American ❑ Native Hawaiian or ❑ Pacific Islander ❑ Do not wish to answer ❑ Unknown			
Ethnicity: ❑ Non-Hispanic ❑ Hispanic ❑ Do not wish to answer ❑ Unknown		Language:			
Is this an injury that occurred at work? ❑ Yes - If so, date of injury: _____ Claim # _____ ❑ No					

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Has this person been a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Name of Primary Insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Sex: ❑ Male ❑ Female	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Co-payment: $

Continue on back

Morton General Hospital
PO Box 1138
521 Adams St.
Morton, WA 98356
360-496-5112

PATIENT IDENTIFICATION LABEL

(3/2012)

INSURANCE INFORMATION CONTINUED…						
Name of Secondary Insurance:						
Subscriber's name:	Subscriber's S.S. no.:		Birth date: / /	Sex: ❑ Male ❑ Female	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of Tertiary Insurance:						
Subscriber's name:	Subscriber's S.S. no.:		Birth date: / /	Sex: ❑ Male ❑ Female	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Do you have an advanced directive? ❑ Yes, it is located _____ ❑ No

Do you have a living will? ❑ Yes, it is located _____ ❑ No

Are you a healthcare surrogate/donor? ❑ Yes ❑ No

Do you have a medical power of attorney? ❑ Yes ❑ No

Who has power of attorney? _____

Power of attorney phone # (home): _____

Power of attorney phone # (work): _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Morton General Hospital or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

HOSPITAL USE ONLY

COMMENTS:

Admitting Clerk Signature _____ **Date** _____

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