Hammond-Henry Hospital
Medical Group

Registration Form

Today's Date: ____/____/____

Patient Information

Patient's Legal Last Name First M.I.:	Marital Status ❑ Sgl ❑ Div ❑ Sep ❑ Mar ❑ Wid	Date of Birth
Patient's Social Security Number (If not a minor): Email		Sex: ❑ Male ❑ Female
Patient's Primary Phone Number	Secondary Phone Number	
Patient Ethnicity: ❑ Caucasian ❑ African American ❑ Hispanic/Latino ❑ Mixed Ethnicity		
Patient's Address City State Zip Code		
Employer / Employer Address City State Zip Code	Contact Number	❑ Full Time ❑ Part Time

Emergency Contact Information

Full Legal Last Name First M.I.:	Relationship
Address City State Zip Code	Contact Number

Guarantor's Information (Parent bringing in minor child)

Full Legal Last Name First M.I.:	Social Security Number	Relationship
Address (if different than above) City State Zip Code		Contact Number
Employer / Employer Address City State Zip Code	Employer Contact #	❑ Full Time ❑ Part Time

Insurance Holders Information

Full Legal Last Name First M.I.:	Date of Birth	Relationship
Address (if different from patients) City State Zip Code		Contact Number
Employer City State Zip Code		❑ Full Time ❑ Part Time

Additional Information

Power of Attorney: ❑ Yes ❑ No If yes, Where is it filed?	
Living Will: ❑ Yes ❑ No If yes, Where is it filed?	
Name of Power of Attorney:	Contact Number:

_____ _____

Patient / Guardian Signature Date