Hammond-Henry Hospital
Medical Group

Registration Form

Today's Date: ____/____/____ Primary Care Provider: ______________________________

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

F-188 (12/17)
Revised (10/18, 10/20, 10/21)