**COQUILLE VALLEY HOSPITAL CLINIC** 790 East 5th Street, Coquille, Oregon 97423 – 541.396.3111 – FAX: 541.396.5891

**PATIENT REGISTRATION**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s First Name | | M.I. | Last Name | | | | | Birthdate | | | SSN |
| Address | | | | | | City | | State | | | Zip Code |
| Cell Phone # | Home Phone # | | | | Work Phone # | | | Marital Status | | | Sex |
| Email Address | | | | Primary Language | | | | Race | | Ethnicity | |
| Pharmacy of Choice | | | | | | | Pharmacy Phone # | | | Pharmacy ID# (if applicable) | |
| Emergency Contact Name | | | | | | | Phone # | | | Relationship to Patient | |
| Primary Employer | | | | | | | Secondary Employer (if applicable) | | | | |
| Address | | | | | | | Address | | | | |
| City, State, Zip | | | | | | City, State, Zip | | | | | |
| Occupation | | | | | | Occupation | | | Work phone # | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (If different than Patient)** | | | | | | | | | |
| NAME (Last, First, M.I.) | | | | Relationship to Patient | | | | | |
| Address | | | City | | | State | | Zip Code | |
| SSN | Cell Phone # | Home Phone # | | | Work Phone # | | Birthdate | | Sex |
| Employer’s Name and Address | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **INSURANCE INFORMATION** | | | | | | | |
| PRIMARY INSURANCE | | | | | SECONDARY INSURANCE | | |
| Insurance Name | | Effective Date | | | Insurance Name | | Effective Date |
| Claims Address | | | | | Claims Address | | |
| Subscriber ID Number | Group Number | | | | Subscriber ID Number | Group Number | |
| Subscriber Name | | Birthdate | | Subscriber Name | | Birthdate | |
| Subscriber SS# | | Relation to Patient | Subscriber SS# | | | Relation to Patient | |

The Patient or Guarantor is responsible for payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

**AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT**

I hereby authorize Coquille Valley Hospital Clinic to release to the above insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Coquille Valley Hospital Clinic all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Coquille Valley Hospital Clinic.

SIGNATURE OF PATIENT/GUARDIAN DATE RELATIONSHIP TO PATIENT

7800-1 REV 6/18