



Hendricks Regional Health Medical Group
Adult Patient Registration

Please Print Clearly

Date _____

Physician _____

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code _____

Home Phone _____

Cell Phone Number _____

Work Phone Number _____

Primary Care Physician _____

Referred By _____
(If different from Primary Care Physician)

Date of Birth _____ Male [] Female []

Single [] Married [] SSN _____

Name of Employer _____

Emergency Contact _____
(not living with you)

Emergency Contact phone _____

Relationship to Emergency Contact _____

Primary Insurance _____

Secondary Insurance _____

Local Pharmacy _____
(Please list name and location)

Mail In Pharmacy _____

Responsible Party (person who will receive statements)

Name _____

Address _____

City _____

State _____ Zip Code _____

Spouse Information

Name _____

Cell Phone Number _____

Work Phone Number _____

Insured Information (only complete if other than patient)

Primary Ins: Insured Name _____
Date of Birth _____ SSN _____
Relationship to Patient _____

Secondary Ins: Insured Name _____
Date of Birth _____ SSN _____
Relationship to Patient _____

Accident Information (if applicable)

Workmen's Comp [] Auto Accident []

Workmen's Comp Contact _____

Workmen's Comp Phone _____

Workmen's Comp Claim # _____

Name of Attorney _____

Phone Number _____

I authorize the physicians and staff of Hendricks Regional Health Medical Group to leave detailed information regarding follow up appointments, test results or other routine medical care on voicemail at the following phone number (____)_____

Patient/Guardian Signature