Rush Copley Medical Center

Patient Registration Form

Date: ________________

PATIENT INFORMATION

Patient Name: ______________________
Marital Status : ______________________
Date of Birth: _______________________
Social Security #: ____________________
Employer Name: _____________________
Employer Address: ___________________
Email Address ________________________________
I'd like to receive important information about RCMC via email. ( ) Yes ( )No

Gender: _______________
Address: ___________________
City/State/Zip: _______________
Home Phone (___)_________________
Cell Phone (___)____________________
Work Phone (___)_________________
Preferred Phone: ( ) Home ( ) Work ( ) Cell
How did you hear about us?______________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: __________________________
Relationship: ___________
Home Phone: (___)_________
Cell Phone: (___)__________
Work Phone:(___)___________

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

( ) Same as patient
Responsible Party's Legal Name: ______________
Relationship to Patient: ______________________
Address:__________________________________
City: ______________________________________

Gender: ( ) Male ( ) Female
Social Security #: _______________
DOB :_________________________
State: ________ Zipcode: __________

INSURANCE INFORMATION

Insurance Co. Name :______________________
Employer: ______________________________
Policyholder Name: ______________________
Social Security #: _______________________

ID#: _______________________________
Group#: ____________________________
Relationship to Patient :_______________
Date of Birth :________________________

Do you have secondary insurance? ( ) Yes ( ) No
Insurance Co. Name: _____________________
Employer: ______________________________
Policyholder Name: ______________________
Relationship to Patient: __________________
Social Security #: _______________________

ID#: _______________________________
Group#: ____________________________
Date of Birth: _________________________

(DO NOT SCAN)