REGISTRATION FORM

Apply Patient Label

☐ Main Campus
☐ Mercy Gilbert

Complaint:	**Time**:	**Date: / /**	**New MRN** ❑ Yes ❑ No
Register account type as:	❑ Inpatient ❑ Observation ❑Outpatient ❑ Other	❑ Emergency	

PATIENT INFORMATION

Last name:	First:	MI:	Sex: ❑ Male ❑ Female
Birth date:____________________ Race____________ Religion______________	Ethnicity: Hispanic / Non-Hispanic	**Language:**________	
Home address:			Home phone no.: ( )
City:		State/Country:	ZIP Code:

INSURANCE INFORMATION

Primary insurance:			
Billing address:			Plan phone no.: ( )
City:		State/Country:	ZIP Code:
Policy #:	Group #:		
Subscriber Last Name:	**First**:	Relationship to patient:	**Date of Birth:**

**Must have DOB

Email Address: ____ **Cell Phone:**__________________________

GUARANTOR

Guarantor's Last Name:	**First**:	**Date of Birth**:	Relationship to patient:
Billing Address (where you receive your mail):			
Home address:			**Cell Phone no**.: ( )
City:		State/Country:	ZIP Code:

OTHER INFORMATION

Family Physician:	Phone no.: ( )	

Registrar Initials:

Copy all insurance cards & photo ID for chart

PCH11476 (Rev. 2 (04/2015))