Southern Indiana Physicians

Ambulatory Registration

PATIENT DEMOGRAPHIC INFORMATION

Legal Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

County of Residence _____ Country _____ SSN _____

Preferred Language of Communication: ☐ English ☐ Spanish ☐ Other _____

Gender: M F Marital Status _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Multiracial ☐ Unknown ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown

Phone _____ Alternate Phone _____ Email Address _____

Preferred Method of Communication: ☐ Email ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Declined

Primary Care Doctor _____ Referring Doctor _____

Employment Status (Circle One) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty

Employer Name _____ Employer Phone _____

Retirement Date (if applicable) _____

Is visit due to accident? _____ If yes, Accident Type _____

Accident: Date _____ Time _____ Location _____

PATIENT GUARANTOR INFORMATION *(Complete if other than patient)*

Patient Relationship to Guarantor _____ Date of Birth _____ Gender: M F

Last Name _____ First Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Employment Status (Circle One) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty

Employer Name _____ Employer Phone _____

Phone: _____ Alternate Phone _____ Email _____

NEXT OF KIN *(Emergency Contact Person Information)*

Patient Relationship to NOK _____ Date of Birth _____

Last Name _____ First Name _____ MI _____

Phone: _____ Alternate Phone _____ Email _____

Employer Name _____ Employer Phone _____

Alternate Contact Information Patient Relationship to Contact Person _____ Date of Birth _____

Last Name _____ First Name _____ MI _____

Phone: _____ Alternate Phone _____ Email _____

INSURANCE INFORMATION

Member Name _____ Date of Birth _____ Name of Insurance _____

SSN _____ Group # _____ Member ID: _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone _____

Secondary Information

Member Name _____ Date of Birth _____ Name of Insurance _____

SSN _____ Group # _____ Member ID: _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone _____

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