INTEGRIS

Please fill out the following form to ensure we are getting your correct information. If you have any questions or need help, our registration staff can assist you. Thank you!

PATIENT INFORMATION

PATIENT DOB: _____ SEX: M or F PATIENT SSN: _____

NAME: _____
LAST *FIRST* *MIDDLE*

ADDRESS: _____ APT # _____

_____
CITY *STATE* *ZIP CODE*

HOME TELEPHONE # ( ) _____ CELL PHONE # ( ) _____

EMAIL ADDRESS: _____

MARITAL STATUS: (PLEASE CIRCLE) SINGLE MARRIED SEPARATED DIVORCED WIDOWED OTHER

IF YOU PREFER A LANGUAGE OTHER THAN ENGLISH, PLEASE LIST IT: _____

DO YOU HAVE A RELIGIOUS PREFERENCE: _____

RACE (PLEASE CIRCLE) A-ASIAN/PACIFIC ISLANDER B- AFRICAN AMERICAN H- HISPANIC/SPANISH

I- AMERICAN INDIAN W- CAUCASIAN N- OTHER

DO YOU HAVE AN ADVANCED DIRECTIVE? Y or N *IF YES, MAY WE MAKE A COPY?*

PATIENT EMPLOYMENT INFORMATION IF PATIENT IS CHILD WRITE "CHILD"

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____
CITY *STATE* *ZIP CODE*

EMPLOYER TELEPHONE # ( ) _____

EMPLOYMENT STATUS: 1-FULL TIME 2-PART TIME 3-DISABLED/UNEMPLOYED 4-SELF-EMPLOYED

5-RETIRED 6-ACTIVE DUTY MILITARY

ARE YOU HERE DUE TO AN ACCIDENT? Y or N

IF YES, WHERE DID ACCIDENT OCCUR? HOME WORK OTHER
IF JOB RELATED, PLEASE LIST SUPERVISOR NAME AND # TO VERIFY _____

DATE AND TIME OF ACCIDENT: _____

GUARANTOR INFO-WHO IS LEGAL GUARDIAN OF PATIENT

DOB _____ SEX: M or F SSN _____

RELATIONSHIP TO PATIENT _____

NAME _____
LAST *FIRST* *MIDDLE*

Due:

See Back Also

Dr:

GUARANTOR EMPLOYMENT INFORMATION

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____

_____

CITY *STATE* *ZIP CODE*

EMPLOYER TELEPHONE # ( ) _____

EMPLOYMENT STATUS: 1-FULL TIME 2-PART TIME 3-DISABLED/UNEMPLOYED 4-SELF-EMPLOYED

5-RETIRED 6-ACTIVE DUTY MILITARY

PLEASE LIST AN EMERGENCY CONTACT

NAME _____

FIRST *LAST* *RELATIONSHIP*

ADDRESS: _____ APT #_____

_____

CITY *STATE* *ZIP CODE*

HOME TELEPHONE # ( ) _____ CELL PHONE # ( ) _____

INSURANCE INFORMATION

NAME OF INSURANCE _____ Policy#_____

CLAIM'S ADDRESS _____ Group#_____

_____

CITY *STATE* *ZIP CODE*

MEMBER OR PROVIDER SERVICES TELEPHONE # _____

SUBSCRIBER INFO-WHO IS POLICY HOLDER OF INSURANCE

DOB_____ SEX: M or F SSN_____ RELATIONSHIP _____

NAME _____

LAST *FIRST* *MIDDLE*

SUBSCRIBER EMPLOYMENT INFORMATION

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____

_____

CITY *STATE* *ZIP CODE*

EMPLOYER TELEPHONE # ( ) _____

EMPLOYMENT STATUS: 1-FULL TIME 2-PART TIME 3-DISABLED/UNEMPLOYED 4-SELF-EMPLOYED

5-RETIRED 6-ACTIVE DUTY MILITARY

WERE YOU REFERRED HERE BY A DOCTOR? IF SO, WHO?_____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

See Back Also