CERNER PATIENT REGISTRATION INFORMATION SHEET

PATIENT INFORMATION

Physician _____ Appt. Date _____ Appt. Time _____

Patient Name _____ Suffix (circle one) II III JR SR
Last First MI

Preferred Name _____ Maiden Name _____

Title (circle one) Captain Colonel Doctor Father Lieutenant Major Reverend Sister

Gender _____ Birthdate _____ SS# _____
(--/--/--)

Marital Status (circle one) Divorced Legally Separated Married Single Unknown widowed

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Wk Ext. _____ Cell _____

Resides at Adress _____

City _____ State _____ Zip _____

Employment Status (circle one) Active Military Duty Full time Not Employed Part Time Retired
Self Employed Unknown

Employer _____
(If self-employed please state name of Company/or Occupation)

Employer Address _____

EMERGENCY CONTACT

Relationship to Patient _____ Name _____

Home Phone _____ Work Phone _____ Wk Ext. _____

2nd EMERGENCY CONTACT

Relationship to Patient _____ Name _____

Home Phone _____ Work Phone _____ Wk Ext. _____

Primary Care MD _____ Please indicate (X) if no primary care MD _____

Referring MD _____ Please indicate (X) if no refering MD _____

Special Needs (ex: patient in wheelchair, hearing impaired) _____

RESPONSIBLE BILLING PARTY

Relationship to Patient _____ Name _____

Gender _____ Birthdate _____ SS# _____
(--/--/--)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Wk Ext. _____

Employment Status (cicle one) Active Military Duty Full Time Not Employed Part Time Retired
Self Employed Unknown

Employer _____
(If self employed please state name of Company/or Occupation)

Employer Address _____

FIRST INSURANCE INFORMATION

Insurer's Relationship to Patient _____ Name _____

Gender _____ Birthdate _____ SS# _____
(--/--/--)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Wk Ext. _____

Employment Status (cicle one) Active Military Duty Full Time Not Employed Part Time Retired
Self Employed Unknown

Employer _____

Insurance Company Name _____

Group Name _____ Group # _____ Effective Date _____

Insured's Policy/Certificate # _____ Patient's Policy/Certificate # _____

SECOND INSURANCE INFORMATION

Insurer's Relationship to Patient _____ Name _____

Gender _____ Birthdate _____ SS# _____
(--/--/--)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Wk Ext. _____

Employment Status (cicle one) Active Military Duty Full Time Not Employed Part Time Retired
Self Employed Unknown

Employer _____

Insurance Company Name _____

Group Name _____ Group # _____ Effective Date _____

Insured's Policy/Certificate # _____ Patient's Policy/Certificate # _____