Kalispell Regional Healthcare - New Patient Registration Form

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name or Initial:	email address:

Mailing Address:	City:	State:	Zip Code:
Physical Address:	**City:**	**State:**	**Zip Code:**

Home Phone: OK to leave message Y N	Cell Phone: OK to leave message Y N	Work Phone: OK to leave message Y N
( ) -	( ) -	( ) -

Date of Birth:	Age:	Gender:	Marital Status:
/ /		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Social Security No:	Employer Name and Address:
- -	

Employment Status:	Student Status:
☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired	☐ Full Time ☐ Part Time ☐ Not a Student

If patient is a minor, please give parent/guardian names and specify relationship to patient:	Race _____ ☐ Other ☐ Unreported/Refused to Report
Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Other _____ Language: ☐ English ☐ Russian ☐ Indian (Includes Hindi & Tamil) ☐ Spanish ☐ Other	Pharmacy Name:
Primary Care Provider:	Referring Provider:

IN CASE OF EMERGENCY

Name of Emergency Contact Person:	Relationship to Patient:	Home Phone No:	Work Phone No:
		( ) -	( ) -

Mailing Address:	City:	State:	Zip Code:

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's Last Name:	First Name:	Middle Name:

Mailing Address, if different from Patient:	City:	State:	Zip Code:

Phone No:	Relationship to Patient:	Date of Birth:	Social Security No:
( ) -		/ /	- -

Employer Name and Address:	Work Phone No:
	( ) -

INSURANCE INFORMATION

Name of Primary Insurance:	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth:
		/ /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Subscriber/Policy No:	Group No:

Name of Secondary Insurance (if applicable):	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth:
		/ /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Subscriber/Policy No:	Group No: