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: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Social Security No: - -	Employer Name and Address:

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