

Alternate Care Site Paper-Based Registration Face Sheet

Patient Information:

Name: _____ DIN: _____ DOB: _____ SSN: _____ Sex: Male Female
Mailing Address: _____ Zip: _____ City: _____ County: _____
Home Phone: _____ Cell/Message Phone: _____
Marital Status: Single Married Widow Divorced Separated
Name of Spouse: _____ Maiden Name: _____
Race/Ethnicity: _____ Primary Language: _____ Translator Required? Yes No
Employer Name: _____ Employers Phone Number: _____
Employer Address if Work Comp related: _____ Occupation: _____

Accident/Injury/Condition Information:

Type of accident: _____ Date of Accident/Injury: _____ Time: _____
Condition: _____
Location: _____
Is there legal action involved? _____ Attorney or Insurance name: _____
Phone _____ Address _____
Policy ID#: _____ Claim#: _____ Adjuster: _____
Is there a police report? _____ Was there another car involved? _____ Who was at fault? _____
If other involved do you have their Insurance information? _____

Guarantor information (Person responsible for bill, co-pay, deductible, SOC etc.)

Name: _____ DOB: _____ SSN: _____
Address: _____ Zip: _____ City: _____
Home Phone Number: _____ Work Phone Number: _____
Employer Address: _____ Occupation: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____
(Last Name, First Name)

Insurance Information: (Copy of Insurance Card and Identification Required)

Name of insurance Coverage: _____ Policy#: _____ Group# _____
Is this a HMO plan? Yes NO. If yes, name of Medical group: _____
Primary Care Physician _____ Co-pay \$ _____

Subscriber Information:

Name _____ Relation _____ DOB _____ SSN _____
Last Name, First Name
Employer _____ Employer's Work Phone _____

Transferring Facility: _____ **Referring Physician:** _____

FOR EMPLOYEE USE ONLY:

If the patient has "No" Insurance was the POE Letter Provided Yes No
Is the patient under 21 or over 65 years of age? Yes No
Is the patient legally disabled? Yes No
Is the patient pregnant? Yes No
Does the patient have children under the age of 21 residing in the home? Yes No
Forms Completed: T & C NOPP MCARE MRL & ADDENDUM Insurance Letter DFR EEAF ITI
_____ Eligibility Verified: Active Inactive Financial Counselor Referral: Yes No
_____ Runner _____ Follow Up