Appomattox Medical Center Patient Registration

Today's Date: Patient's Social Security Number:

Last Name: First Name:

Middle Name: Sr. : ☐ Jr. ☐ I ☐ II ☐ III☐ Other:

Mail Address:

City: State: Zip code:

Physical Address (if different than mailing address):

City: State: Zip code:

Home Phone Number: Cell Phone Number:

Employer :

Employer address:

Employer Phone number: Sex: Male ☐ Female ☐

Date of Birth of Patient: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Spouse's Information

Spouse's Social Security Number:

Last Name: First Name:

Middle Name: Sr. : ☐ Jr. ☐ I ☐ II ☐ III☐ Other:

Mail Address:

City: State: Zip code:

Physical Address (if different than mailing address):

City: State: Zip code:

Home Phone Number: Cell Phone Number:

Employer :

Employer address:

Employer Phone number: Sex: Male ☐ Female ☐

Date of Birth of Spouse:

If Minor: Mother/Guardian Information

Last Name: First Name:

Middle Name: ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III Other:

Home Phone Number: Cell Phone Number:

Mailing Address (if different than address above):

City: State: Zip code:

Date of Birth of Parent/ Guardian: Emergency contact : ☐ Yes ☐ No

If Minor: Father/Guardian Information

Last Name: First Name:

Middle Name: ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III Other:

Home Phone Number: Cell Phone Number:

Mailing Address (if different than address above):

City: State: Zip code:

Date of Birth of Parent/ Guardian: Emergency contact : ☐ Yes ☐ No

Emergency contact (not in the same household)

Last Name: First Name:

Middle Name: ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III Other:

Home Phone Number: Cell Phone Number:

Mailing Address (if different than address above):

City: State: Zip code:

Date of Birth of Parent/ Guardian: Emergency contact : ☐ Yes ☐ No

Ethnicity

☐ American Indian/Native American ☐ Asian ☐ Black or African American

☐ Native Hawaiian ☐ Caucasian (white) ☐ More than 1 race

☐ refused to report ☐ Other Pacific Islander

I authorize release of medical records and information necessary to process my insurance claims, and authorize payment of my insurance benefits directly to Appomattox Medical Center/Larry F. Smith, M. D. for services rendered. A photocopy of authorizations shall be considered effective and as valid as the original. This authorization shall remain valid for one year.

Signature of patient or responsible party:

Print name of patient or responsible party:

Date: