PATIENT REGISTRATION

KETTERING Physician Network
KETTERING HEALTH NETWORK

PATIENT INFORMATION

PHYSICIAN NAME | PRIMARY CARE PHYSICIAN

PATIENT FIRST NAME | MIDDLE NAME | LAST NAME | SSN

SEX ❒ MALE ❒ FEMALE | DATE OF BIRTH | ALIASES | MARITAL STATUS ❒ MARRIED ❒ WIDOWED ❒ SINGLE ❒ DIVORCED ❒ OTHER

PERMANENT STREET ADDRESS | HOME PHONE (check if preferred contact number) ❒

CITY | WORK PHONE (check if preferred contact number) ❒

STATE | ZIP | CELL PHONE (check if preferred contact number) ❒

EMERGENCY CONTACT NAME | RELATIONSHIP TO PATIENT | EMER. CONTACT HOME PHONE (check if preferred contact number) ❒

STREET ADDRESS | WORK PHONE (check if preferred contact number) ❒

CITY | STATE | ZIP | CELL PHONE (check if preferred contact number) ❒

GUARANTOR

RESPONSIBLE PARTY ❒ SELF ❒ SPOUSE ❒ FATHER ❒ MOTHER ❒ OTHER | GUARANTOR FIRST NAME | MIDDLE NAME | LAST NAME

GUARANTOR SEX ❒ MALE ❒ FEMALE | GUARANTOR DATE OF BIRTH | GUARANTOR HOME PHONE | GUARANTOR SSN

GUARANTOR EMPLOYER ADDRESS | GUARANTOR EMPLOYMENT STATUS | GUARANTOR WORK PHONE

CITY | STATE | ZIP | GUARANTOR EMPLOYER NAME

PRIMARY INSURANCE

PRIMARY INSURANCE NAME | DATE EFFECTIVE FROM | SECONDARY INSURANCE ADDRESS

PATIENT RELATIONSHIP TO SUBSCRIBER ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER | INSURANCE PHONE | SUBSCRIBER INSURANCE ID NUMBER | GROUP NUMBER

NAME OF SUBSCRIBER | DATE OF BIRTH | EMPLOYER NAME

EMPLOYER STATUS ❒ FULL TIME ❒ PART TIME ❒ NOT EMPLOYED ❒ SELF-EMPLOYED ❒ RETIRED ❒ ACTIVE MILITARY DUTY ❒ STUDENT-FULL TIME ❒ STUDENT-PART TIME ❒ OTHER

COVERED THROUGH ❒ EMPLOYMENT ❒ RETIREMENT ❒ COBRA ❒ OTHER | EMPLOYER SIZE ❒ 1-19 ❒ 20-99 ❒ 100+ | COPAY AMOUNT

SECONDARY INSURANCE

SECONDARY INSURANCE NAME | DATE EFFECTIVE FROM | SECONDARY INSURANCE ADDRESS

PATIENT RELATIONSHIP TO SUBSCRIBER ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER | INSURANCE PHONE | SUBSCRIBER INSURANCE ID NUMBER | GROUP NUMBER

NAME OF SUBSCRIBER | DATE OF BIRTH | EMPLOYER NAME

EMPLOYER STATUS ❒ FULL TIME ❒ PART TIME ❒ NOT EMPLOYED ❒ SELF-EMPLOYED ❒ RETIRED ❒ ACTIVE MILITARY DUTY ❒ STUDENT-FULL TIME ❒ STUDENT-PART TIME ❒ OTHER

COVERED THROUGH ❒ EMPLOYMENT ❒ RETIREMENT ❒ COBRA ❒ OTHER | EMPLOYER SIZE ❒ 1-19 ❒ 20-99 ❒ 100+ | COPAY AMOUNT

INJURY

IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT? ❒ YES ❒ NO | DID THIS INJURY OCCUR AT WORK? ❒ YES ❒ NO

AUTHORIZATION/ RELEASE

I authorize the physician/physician group above to provide treatment and or tests to me. In signing this agreement, I certify that the above stated facts are correct. I/We hereby assign and authorize payment of all insurance benefits directly to the physician/physician group above. I/We hereby authorize the physician/physician group above to furnish information from the patient's medical records to insurers, compensation carriers, healthcare facilities, or other agencies which may be providing financial assistance for the patient's care. I understand that I am financially responsible for any balance not covered by insurance.

DATE | SIGNATURE OF INSURED OR AUTHORIZED PERSON