Harrison County Hospital
PRE-REGISTRATION FORM

(Please Print)

Expected due date:	OB Dr:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Ms. ❑ Mrs. ❑ Mr. ❑ Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid

(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	Race: ❑American Indiana ❑African American ❑Hispanic ❑Multi Racial ❑White Ethnic Group: ❑Hispanic or Latino ❑ Non Hispanic or Latino

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Employer:	Employer Address:	Employer phone no.: ( )

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Employer:	Employer address:	Employer phone no.: ( )

Primary insurance and address:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's Relationship to subscriber:	Subscriber's Address (if different):				
Secondary insurance and address:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

IN CASE OF EMERGENCY

Name:	Address:	
City:	State:	Zip:
Phone: ( )	Relationship to Patient:	
HIPAA Info: (friends and family the doctor may talk to about your condition)	Power of Attorney: (include phone number)	

Office Use: Clerk:	Comments:

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