



Online Pre-Registration Information

Review the registration information and make sure you have all of the required data prior to coming to the hospital. This will speed up the registration process and save you time.

Birth date: _____
Last name: _____ First name: _____ Middle Name: _____
Maiden Name: _____
Address: _____
City: _____ State: _____ Zip: _____
County: _____
Phone: _____ Cell Phone: _____ Email: _____
Birth Date: _____ Birth Place: _____
Social Security Number: _____
Sex: _____ Marital status: _____ Religion: _____ Race: _____

Employer:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

Spouse:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Birth Place: _____

Spouse Employer:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

For Minor Child:

Father: Name _____ Fathers Date of Birth: _____
Mother: Name _____ Mothers Date of Birth: _____

Fathers Employer:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

Mothers Employer:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

Notify in Case of Emergency:

Name _____
Relationship to patient _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work phone _____
Cell phone _____

Guarantor Information:

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell phone _____ Social Security Number _____
Birth date _____

Guarantor's employer:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

Insurance information:

Primary Insurance:

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone _____
Subscriber Name _____
Subscriber Address _____
City _____ State _____ Zip _____
Subscriber Employer _____
Subscriber's relationship to patient _____
Subscriber's birth date _____
Policy ID # _____ Policy Group # _____

Secondary Insurance:

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone _____
Subscriber Name _____
Subscriber Address _____
City _____ State _____ Zip _____
Subscriber Employer _____
Subscriber's relationship to patient _____
Subscriber's birth date _____
Policy ID # _____ Policy Group # _____

Services needed: (i.e. Lab, Radiology, Outpatient Surgery, etc.)

Doctor ordering services:

Please print this information and bring it with you to the Columbia Memorial Hospital, it will save you time at registration.