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.