

**PATIENT REGISTRATION**  
**(PLEASE COMPLETE THIS FORM IN ITS ENTIRETY)**

**PATIENT INFORMATION:**

Birth Date: \_\_\_\_\_ Marriage Status: \_\_\_\_\_ Sex: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer \_\_\_\_\_ Email: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:** (If you are the patient you may put SAME AS ABOVE)

Birth Date: \_\_\_\_\_ Marriage Status: \_\_\_\_\_ Sex: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer \_\_\_\_\_ Email: \_\_\_\_\_

**\*\*\* PLEASE PRESENT CURRENT INSURANCE CARDS TO THE RECEPTIONIST \*\*\***

**Emergency Contact:** name of Local Friend or Relative (not living at the same address)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Person Gender: \_\_\_\_\_

Contact DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

I consent to the use of disclosure of my protected health record by my Provider at the Daviess Community Hospital Clinics for the purpose of diagnosing or rendering treatment to myself or my dependent, acquiring payment for my health care claims, or to perform health care procedures. I hereby assume payment of all charges and authorize and direct payment from any insurance company to include but not limited to Medicare, Medicare Supplements, made directly to my Provider at Daviess Community Hospital Clinics in agreement with Federal, State, local and agency, I agree to pay collection agency fees, and reasonable attorney and/or court costs.

I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Daviess Community Hospital, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to

Daviess Community Hospital or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Daviess Community Hospital, and/or their contractors, servicers, debt collection agencies, or agents.

**I UNDERSTAND MY COPAY IS DUE AT EACH VISIT. IF I AM UNABLE TO MAKE THE REQUIRED COPAYMENT, THE APPOINTMENT MAY BE RESCHEDULED.**

SIGNATURE OF PATIENT/PARTEN/GUARDIAN: \_\_\_\_\_ Date: \_\_\_\_\_

If the above signature does not belong to the patient, please list your relationship: \_\_\_\_\_