

Patient Registration Form

Baton Rouge General Physicians

Patient # _____

Patient Referred by: _____ Primary Care Physician: _____								
Patient Information	Last Name		First Name		Middle Initial			
	Social Security Number _____-_____-_____		Date of Birth ____/____/____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
	Race: <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Black / African American <input type="checkbox"/> Other <input type="checkbox"/> White / Caucasian				Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			
					Preferred Language: <small>(for communicating with Physician & Staff)</small>			
					Religion:			
	Home Address					Home Phone Number		
	City			State	Zip Code	Cell Phone Number		
	Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No --- <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time				
	Name of Employer / School				Email Address			
Guarantor Information	Person Responsible for this account: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Other-please specify/Relationship: _____ <small>(* If patient is Responsible Party you may skip this section)</small>							
	Last Name		First Name		Middle Initial			
	Social Security Number _____-_____-_____		Date of Birth ____/____/____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
	Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No --- <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time				
	Home Address					Home Phone Number		
	City			State	Zip Code	Cell Phone Number		
	Name of Employer / School				Email Address			
In Case of Emergency Notify	Name					Relationship to Patient		
	Address					Phone Number		
Insurance Coverage	Primary Insurance Name				Secondary Insurane Name			
	Policy #		Group #		Policy #		Group #	
	Name on Insurance Card (Subscriber)				Name on Insurance Card (Subscriber)			
	SSN of Cardholder (Subscriber) _____-_____-_____		Date of Birth ____/____/____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN of Cardholder (Subscriber) _____-_____-_____		Date of Birth ____/____/____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Worker's Comp	Is this a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Employer at the time of injury					
	Date of Injury ____/____/____		Employer's Address					
	Employer's Phone #		City		State		Zip Code	