SOUTHWEST GENERAL HEALTHCARE CENTER

PATIENT REGISTRATION

A. PATIENT

Please Print Legibly on Form				**Account #**
Last Name	First Name			Middle Initial
Address	Apt #	City	State	Zip
Home Phone:	Mobile Phone:			Work Phone:
DOB (mm/dd/yy)	Gender ☐ Male ☐ Female			SSN #
E-mail Address				
Employment Status ☐ Employed ☐ Un-Employed ☐ Retired ☐ Student ☐ Other:				
Employer Name				

B. EMERGENCY CONTACT

Last Name	First Name	Middle Initial
Home Phone	Mobile Phone	Work Phone
Relationship to Patient ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ☐ Friend ☐ Other:		

C. INSURANCE (if applicable)

Primary Insurance (copy of card must be on file)	**Check here** ☐ if Name, SSN & DOB same as patient.
Insurance Name	
Subscriber (Insured) Name	SSN #
Relationship of Patient to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	DOB (mm/dd/yy)
Secondary Insurance (copy of card must be on file)	**Check here** ☐ if Name, SSN & DOB same as patient.
Insurance Name	
Subscriber (Insured) Name	SSN #
Relationship of Patient to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	DOB (mm/dd/yy)

D. ACCIDENT (if applicable)

Work related accident? ☐ Yes ☐ No **Auto or Other Type Accident?** ☐ Yes ☐ No (if yes, fill out below)			
Insurance Name			Phone
Address	City	State	Zip
Policy #		Agent/Adjuster Name	
Claim #	Accident Date	Accident State	

E. CHIEF COMPLAINT

Please provide specific clinical symptoms and behaviors that support diagnosis. Primary reason for your visit today.

_____

_____

_____

_____

20 Barkley Circle Suite 202 Fort Myers FL 33907 Phone: (239)931-3368 Fax: (239)931-1262 Email: info@swghealthcare.com Web:www.swghealthcare.com

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Patient Registration Cont.

PATIENT

Please Print Legibly on Form		Account #
Last Name	First Name	Middle Initial

F. ILLNESSES, HOSPITALIZATIONS, SURGICAL PROCEDURES/ (if applicable)

Please list all major illnesses, hospitalizations or surgical procedures:

_____

_____

_____

_____

G. MEDICATION (if applicable)

Please list all medications (prescriptions, over-the-counter and natural/herbal medicines):

_____

_____

_____

_____

H. ALLERGIES(if applicable)

Please list all known allergies including drugs, food animals, etc.:

_____

_____

_____

_____

- ✓ **I understand that it is required that I bring to my appointment my Insurance Card and a Photo ID.**
- ✓ **I have read the Consent to Receive Medical Services-Financial Responsibility Form and I understand that some charges may not be covered by my insurance plan and that I may be responsible for payment, in full, of these charges.**

_____ _____

PATIENT PRINTS FULL NAME **SIGNATURE**

DATE _____

THANK YOU FOR TAKING THE TIME AND EFFORT TO FILL OUT THIS PATIENT REGISTRATION FORM AS COMPLETELY AND AS ACCURATELY AS POSSIBLE. YOUR INFORMATION WILL ALLOW US TO GIVE YOU THE APPROPRIATE CARE.

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