Deckerville Healthcare Services
Patient Registration

Patient Information

Last Name: ________________________________ First: ___________________________ MI: ________

Birth Date: ________________ Age: ________ S.S.# ______-_____-______ Marital Status: S M W D

Street Address: ____ P.O. Box ___________________

City: ____ State: _______________ Zip: ___________

Phone:(_____)_____________ 2nd Phone:(_____)____________ Race: ________ Ethnicity:________

Patients Employer: _______________________ Street Address: _________________________________

City: _________________________ State: __________ Zip: __________ Phone: (____)_____________

Are you allergic to any medications? ____

Advance Directive (POA) _______________ FamilyPhysician: __________________________________

Parents/Guarantors Information (Complete if patient is a minor and/or you are the insurance policyholder)

Father Last Name: __________________________________ First: ______________________________

Mother Last Name: _________________________________ First: ______________________________

Father Birth Date: _________S.S.# ___-_____-____Mother Birth Date: ______S.S.# ____-___-_____

Street Address: ____ P.O. Box ___________________

City: ____ State: _______________ Zip: ___________

Home Phone:(_____)________________ Cell: (____)________________ Work: (____)____________

Employer: _________________Status:___________ Address: __________________________________

City: ______________________________ State: __________ Zip: _______ Phone: (____)____________

Emergency Contact / Next of Kin (Must be someone other than names given above)

Name: ____________________________________Relationship: _____________Phone: (____)________

Insurance Information

Primary Insurance: _____________________ Policyholder Name: _______________________________

Contract/I.D. # ________________ Policyholder Birth Date: ________ Employer: ________________

Secondary Insurance: ____________________ Policyholder Name: ______________________________

Contract/I.D. # ________________ Policyholder Birth Date: ________ Employer: ________________

How did you hear about us? ____

Each patient (or responsible party) is financially responsible for services rendered. While we are pleased to submit charges to an insurance company, the OBLIGATION FOR PAYMENT remains that of the patient and we urge payment within our usual 30-day terms. Should you have any questions concerning fees or terms, please don't hesitate to ask.

Patient/Parent/Guarantor Signature __________________________________ Date: _______________