HCA Patient Account Services Manual Registration Form

Patient Information

Fax #208-529-7076

Patient Last Name, First Name, Middle Name			Patient's Street Address		
Social Security No.	Race	Date of Birth	City and State		Zip Code
Marital Status / Spouse's Name/if applicable			Patient's Telephone Number ( )		Religious Preference
Patient's Employer			Employer Telephone Number ( )		Occupation
Employer Street Address			Employer City and State		Zip Code
Spouse's Employer			Spouse's Employer Telephone Number ( )		Occupation
Spouse's Employer Street Address			Spouse's Employer City and State		Zip Code

If minor/Responsible party

Responsible Party Last Name, First Name, Middle Name			Responsible Party Street Address		
Social Security Number	Date of Birth	Sex	City and State		Zip Code
Marital Status / Spouse's Name			Race	Responsible Party Telephone Number ( )	Cell No:
Responsible Party Employer			Employer Telephone Number ( )		Occupation
Employer Street Address			Employer City and State		Zip Code

Next of Kin

Name of Next of Kin / Person to Notify	Relationship to Patient	Home Telephone Number ( )	Work Telephone Number ( )
Street Address	City and State		Zip Code

Physician Information

Family Physician

Reason for Admission/Testing _____

*Insurance Company/Policy #/Policy Holder*_____

*Patient's E-Mail Address:*_____