Hunt Regional Medical Center

Outpatient Registration Form

****Complete these shaded sections if you have been a patient at HRMC before AND there are no changes to your demographics.*

Date: ____________________ *Current Time:* _____________________ *Appointment Time (if applicable):*____________

***PATIENT INFORMATION			
Last Name:	**First Name:**		**MI:**
Social Security #:	**Date of Birth:**	**Sex: [ ]M [ ]F**	
Physical Address:			
City:	**State:**	**Zip:**	
Telephone # Home:	**Cell:**	**Other:**	
Mailing Address *(if different from physical)*:			
City:	**State:**	**Zip:**	
[ ]Single **[ ]Married**	**[ ]Widowed**	**[ ]Divorced**	
Employer Name:			
Employer Address:		**Work #**	
City:	**State:**	**Zip:**	

EMERGENCY CONTACT INFORMATION	
Name:	
Relation to Patient:	**Telephone #**

PARENT/GUARDIAN INFORMATION/ Next of Kin *(if patient is under 18)*			
Last Name:	**First Name:**		**MI:**
Social Security #:	**Date of Birth:**	**Relation to Patient:**	
Employer Name:			
Employer Address:		**Work #**	
City:	**State:**	**Zip:**	

***PRIMARY INSURANCE COMPANY INFO	***SECONDARY INSURANCE COMPANY INFO *(if applicable)*
Policy Holder:	**Policy Holder:**
Date of Birth:	**Date of Birth:**
Social Security #:	**Social Security #:**
Relation to Patient:	**Relation to Patient:**

I acknowledge that the above information is correct and current to the best of my knowledge.

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Signature

For Office Use Only

Comments: ____

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Registrar:____