Revised 4/13/2016

CROSS TRAILS MEDICAL CENTER
Patient Registration Form

Patient Information

Last Name	First Name	MI	Social Security Number
/ / M / F	Single / Married / Widowed / Divorced		
Birthdate Sex	Marital Status		
Address			
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	

Ok to leave message? Yes / No

Email Address:_____

Emergency Contact	Relationship to Patient	Home Phone	Work Phone

Responsible Party Information (if other than the patient)

Last Name	First Name	MI	Social Security Number
/ / M / F	Single / Married / Widowed / Divorced		
Birthdate Sex	Marital Status		
Address			
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	

Do you have a preferred pharmacy? Yes / No

Pharmacy:_____ Phone Number:_____

Address:_____

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FOR PRIVATE INSURANCE PATIENTS -

Cross Trails Medical Center utilizes our in-house laboratory to process any labwork you may need.
If your insurance company requires your lab work to be sent to a specific lab please indicate below.

LabCorp	Southeast Hospital Lab
LabOne	St. Francis Lab
Quest	Other (please specify)_____

DUE TO GOVERNMENT REGULATIONS WE ARE REQUIRED TO ASK THE FOLLOWING INFORMATION:

What is your race?

Asian	Black/African American	Pacific Islander	More than one race
White	Native Hawaiian	American Indian/Alaska Native	Refused to Report

What is your ethnic background?

Hispanic/Latino Non-Hispanic/Latino Refused to Report

What language other than English would best serve you?_____

What is your Gender Identity?

Male	Transgender Male/Female to Male	Gender Queer	Choose not to disclose
Female	Transgender Female/Male-to-Female	Other	

What is your sexual orientation?

Straight or heterosexual	Bisexual	Don't Know
Lesbian, gay or homosexual	Something Else	Choose not to disclose

Are you a U.S. Veteran?

Yes No

What is your yearly household income? _____ Refused

How many persons are in your household? _____

Authorization : I hereby authorize the physician above to furnish information to insurance carriers concerning myself and my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance.

Authorization : I hereby authorize payment of medical benefits to Cross Trails Medical Center.

Authorization : I hereby give permission for laboratory treatments and procedures, health history and physical assessment, mental health evaluation and treatment to be performed.

Authorization : I hereby request that my medical records, laboratory results, x-ray results and all pertinent information to be released to Cross Trails Medical Center.

_____ _____

Date Signature of patient, parent or guardian