HILL PARK MEDICAL CENTER
PATIENT REGISTRATION FORM

Name: ______________________________ Date: __________

Address: ______________________________

City: ______________________________ State: ______ Zip: ________

Contact: ______________________________

Home Phone: ______________ Work: ______________ Cell: ______________

Email: ______________________________

Date of Birth: ______________ Age: ________ Gender: ______________

SSN#: ______________________________

I am: ❑ Married ❑ In a Partnership ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

I live with: ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone

Occupation: ______________________________ Hours of work per week: ________

Name of Spouse/Parent: ______________________________

Emergency Contact Person: ______________________ Phone Number: ______________

How did you hear about Hill Park Medical Center? ______________________________

____

____

Reason for today's visit: ______________________________

____

____

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices: ______________________________
signature

I have elected not to receive a copy of the Notice of Privacy Practices: ______________________________
signature