



PATIENT REGISTRATION
PLEASE FILL OUT FORM COMPLETELY

Patient Information:

Patient: _____ Date of Birth: _____
Marital Status: _____ Age: _____ Race: _____ Sex: _____ Allergies: _____
Address: _____ City/State/Zip: _____
Home Phone: (____) _____ Alternate Phone: (____) _____
Social Security Number: _____ Employer: _____
Referred By: _____

Emergency Contact Information:

Name: _____ Relationship: _____
Phone Number: _____

Guarantor Information:

Name: _____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Address: _____
Employer: _____ Phone Number: _____

I, _____, give consent for Brentwood Hospital to review my credit history through Equifax.

Signature: _____

Primary Insurance: _____ **Policy #** _____
Insured: _____ Relationship: _____ DOB: _____
Policy Holder SSN: _____ Employer: _____

Secondary Insurance: _____ **Policy #** _____
Insured: _____ Relationship: _____ DOB: _____
Policy Holder SSN: _____ Employer: _____

HOSPITAL USE ONLY:

Medical Record #: _____ Account #: _____
Admit Date: _____ Admit Time: _____ Admit By: _____
Attending Physician: _____ Admitting Diagnosis: _____
Unit: _____ Room #: _____ Previous Admit Date: _____