Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name:_____First Name:_____Middle Initial: _____

Date of Birth:_____Male or Female:____Marital Status: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Phone Number:_____ Social Security #: _____

May We Call You at Home? Yes _____No ___May we leave a message? Yes____No ___

Email address (for Patient Portal): _____

EMPLOYER:

Employer's Name: _____

Street Address_____ City: _____

State_____ Zip Code:_____Work Phone Number:_____

Occupation: _____

GUARANTOR (Person Financially Responsible for the Patient)

Name:_____Relationship to the Patient: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Phone Number:_____Social Security #: _____

Employer:_____Occupation: _____

Street Address: _____

City: _____State: _____ Zip Code: _____Phone Number: _____

PRIMARY INSURANCE COMPANY:_____Phone #:_____

Street Address: _____

City:_____State:_____Zip Code: _____

Policy #:_____Group#:_____Subscriber Name: _____

Subscriber Date of Birth: _____Relationship to Patient: _____

SECONDARY INSURANCE COMPANY:_____Phone #: _____

Street Address: _____

City: _____State: _____Zip Code: _____

Policy #:_____Group#: _____

Subscriber Name: _____

Subscriber Date of Birth:_____Relationship to Patient: _____