EvergreenHealth
GERIATRIC CARE

Geriatric Care Registration Form

evergreenhealth.com

Patient Information

Legal Last Name				
Legal First Name				Middle Initial
Birth Date / /	Gender M/F	Race		Ethnic Group
Mailing Address		City	State	Zip Code
Primary Phone ( ) -		OK to Leave Detailed Message? Y / N		
Primary Language	Interpreter? Y/N	Primary Care Provider		
Referring Provider				

Employer Information

Employment Status (full, part, retired etc.)	Employer Name/ Or Retirement Date

Primary Insurance- MUST COMPLETE INSURANCE FIELDS

Patient's Relationship to Subscriber		Subscriber DOB / /
Legal Last Name	Legal First Name	Gender M / F
Insurance Name	ID Number	Group Number

Secondary Insurance (if applicable)

Patient's Relationship to Subscriber		Subscriber DOB / /
Legal Last Name	Legal First Name	Gender M / F
Insurance Name	ID Number	Group Number

Emergency Contact

Patient's Relationship to Emergency Contact	
Legal Last Name	Legal First Name
Birth Date / /	Primary Phone ( ) -

Emergency Contact

Patient's Relationship to Emergency Contact	
Legal Last Name	Legal First Name
Birth Date / /	Primary Phone ( ) -

Emergency Contact

Patient's Relationship to Emergency Contact	
Legal Last Name	Legal First Name
Birth Date / /	Primary Phone ( ) -