Baton Rouge General Physicians

Patient Registration Form

Baton Rouge General Physicians

Rev. (02/14)

Patient #

Patient Referred by: _____ Primary Care Physician: _____

Patient Information

Last Name | First Name | Middle Initial

Social Security Number _____-_____-_____

Date of Birth _____/_____/_____

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced

Race: ☐ American Indian / Alaska Native ☐ Asian / Pacific Islander ☐ Black / African American ☐ Other ☐ White / Caucasian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: (for communicating with Physician & Staff)

Religion:

Home Address | Home Phone Number

City | State | Zip Code | Cell Phone Number

Are you employed? ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No --- ☐ Full-time ☐ Part-time

Name of Employer / School | Email Address

Guarantor Information

Person Responsible for this account: ☐ Patient ☐ Parent ☐ Other-please specify/Relationship: _____

(* If patient is Responsible Party you may skip this section)

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Social Security Number _____-_____-_____

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In Case of Emergency Notify

Name | Relationship to Patient

Address | Phone Number

Insurance Coverage

Primary Insurance Name | Secondary Insurane Name

Policy # | Group # | Policy # | Group #

Name on Insurance Card (Subscriber) | Name on Insurance Card (Subscriber)

SSN of Cardholder (Subscriber) _____-_____-_____ | Date of Birth ____/____/____ | Sex ☐ M ☐ F

SSN of Cardholder (Subscriber) _____-_____-_____ | Date of Birth ____/____/____ | Sex ☐ M ☐ F

Worker's Comp

Is this a work-related injury? ☐ Yes ☐ No | Name of Employer at the time of injury

Date of Injury ____/____/____ | Employer's Address

Employer's Phone # | City | State | Zip Code