000-0449 Rev. (02/14)

Baton Rouge General Physicians

Patient Registration Form

Baton Rouge General Physicians
Obstetrics & Gynocology

Patient #

Patient Referred by: ______________________ Primary Care Physician: ______________________

Patient Information

Field			
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)

Field			
Last Name	First Name	Middle Initial	
Social Security Number ______-______-______	Date of Birth _____/_____/_____	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced
Are you employed? ☐ Yes ☐ No	Are you a student? ☐ Yes ☐ No --- ☐ Full-time ☐ Part-time		
Home Address	Home Phone Number		
City	State	Zip Code	Cell Phone Number
Name of Employer / School	Email Address		

In Case of Emergency Notify

Field	
Name	Relationship to Patient
Address	Phone Number

Insurance Coverage

Primary			Secondary		
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

Field			
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