Orchard Medical Center, S.C. (OMC)
REGISTRATION FORM
Please Print – Complete ONE Form for <u>EACH</u> Patient
Chart No# _____

Today's Date: PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	
Date of Birth:	Age:	Sex:Male□	Female□
Street Address:			
Street Address:	City:	State:	Zip:
SSN:	Driver's License No#:		State:
Single: □ Married: □ Divorced: □ Widowed: □	Occupation:		
Patient's Employer:	Employer's Tele No#:		
Employer's Address:	City:	State:	Zip:
Patient's HOME No#:	Patient's CELL No#:		
Patient's WORK No#:	Patient's Email:		
If married, may we release medical information to your spouse?	Yes □	No□	
Spouse's Last Name:	First:	Middle:	
Spouse's CELL No#:	Spouse's WORK No#:		

PRIMARY INSURANCE INFORMATION

Name of Policy Holder/Subscriber:		Policy Holder's Date of Birth:	
SSN of Policy Holder/Subscriber:		Policy Effective Date:	
Policy Holder/Subscriber's Relationship to Patient:		Sex: Male □ Female □	
Is this NEW Insurance Since 1-1-14 YES □ NO □	Has Your Insurance Changed Since 1-1-14 YES □	NO □	
Policy Holder/Subscriber's Address (if different than patient's):			
Policy Holder/Subscriber's Address	City:	State:	Zip:
Group No#	Policy ID No#:	Group Employer:	
Insurance Co. Name:	Type: Medicare □ PPO □ POS □ HMO □Other:		
Copay Amount:	Insurance Co. Address:		
Insurance Co. Address:	City:	State:	Zip:

SECONDARY INSURANCE INFORMATION

Name of Policy Holder/Subscriber:		Policy Holder's Date of Birth:	
SSN of Policy Holder/Subscriber:		Policy Effective Date:	
Policy Holder/Subscriber's Relation to Patient:		Sex: Male □ Female □	
Is this NEW Insurance Since 1-1-14 YES □ NO □	Has Your Insurance Changed Since 1-1-14 YES □	NO □	
Policy Holder/Subscriber's Address (if different than patient's):			
Policy Holder/Subscriber's Address	City:	State:	Zip:
Group No#	Policy ID No#:	Group Employer:	
Insurance Co. Name:	Type: Medicare □ PPO □ POS □ HMO □ Other:		
Copay Amount:	Insurance Co. Address:		
Insurance Co. Address:	City:	State:	Zip:

Emergency Contact Information:

Name of Emergency Contact:	Relationship:		
Address:	Telephone:		
Address:	City:	State:	Zip:
Is Orchard Medical Center, S.C. Authorized to Release Information to this Person? Yes □ No □			
Patient Signature:	Date:		