NEW PATIENT INFORMATION

Plumas District Hospital is committed to protecting your personal information. In an effort to reduce exposure of your personal information, please complete this form prior to meeting with our registration staff.

Patient Contact Information

Patient Name:_____
First *Middle* *Last*

Soc. Sec. Number: _____ – _____ – _____ **Date of Birth:** _____/_____/_____

Gender: ❑ Male ❑ Female

Reason for Today's Visit: _____

_____

_____

Physical Address:

_____
Street *City* *State* *Zip* *County*

Mailing Address:

_____
Street *City* *State* *Zip* *County*

Home Phone: _____ **Cell Phone:** _____

Email: _____

Patient Demographics

Race *(Select One or More)***:**

❑ White ❑ Asian ❑ Black or African American ❑ Multi-Racial ❑ Other
❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Ethnicity *(Select One)***:**

❑ Hispanic/Latino ❑ Not Hispanic/Latino

Nickname: _____

Marital Status:

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Life Partner ❑Other:_____

Maiden Name *(if applicable)*: _____

Spouse Information *(If married, please fill out this section)*

Spouse Name:_____
First *Middle* *Last*

Soc. Sec. Number: _____ – _____ – _____ **Date of Birth: _____/_____/_____**

Physical Address:

_____
Street *City* *State* *Zip* *County*

Mailing Address:

_____
Street *City* *State* *Zip* *County*

Home Phone: _____ Cell Phone: _____

Employer: _____

Advance Directive

Do you have an Advance Directive? ❑ Yes ❑ No

If so, **where is it located?** _____ ❑ Unsure

If not, **would you like information regarding Advance Directive?** ❑ Yes ❑ No

Primary Care Provider: _____

Employer Information

Employer Name *(Or School)*: _____

Occupation/Job Title: _____

Employer's Phone: _____

Employer's Address:_____
Street *City* *State* *Zip* *County*

Responsible Party (Guarantor)

❑ **Self** *If you are 18 years of age or older, you are your own guarantor.*
You do not need to complete this section.

Guarantor Name:_____
First *Middle* *Last*

Relationship to Patient: _____

Soc. Sec. Number: _____ – _____ – _____ **Date of Birth:** _____/_____/_____

Physical Address: _____
Street *City* *State* *Zip* *County*

Mailing Address: _____
Street *City* *State* *Zip* *County*

Home Phone: _____ **Cell Phone:** _____

Email: _____

Primary Insurance Plan

Policy Holder Information:

Name: _____

Gender: ❑ Male ❑ Female **Relationship to Patient:** _____

Soc. Sec. Number: _____ – _____ – _____ **Date of Birth:** _____/_____/_____

Address:_____
Street *City* *State* *Zip* *County*

Insurance Company: _____

Billing Address: _____
Street *City* *State* *Zip* *County*

Member ID#: _____ **Group #:** _____

Effective Date: _____ **Expire Date:** _____

Secondary Insurance Plan

❑ **N/A**

Policy Holder Information:

Name: _____

Gender: ❑ Male ❑ Female **Relationship to Patient:** _____

Soc. Sec. Number: _____ – _____ – _____ **Date of Birth:** _____/_____/_____

Address:_____

Street *City* *State* *Zip* *County*

Insurance Company: _____

Billing Address: _____

Street *City* *State* *Zip* *County*

Member ID#: _____ **Group #:** _____

Effective Date: _____ **Expire Date:** _____

Other Insurance

Do you have other Insurance? ❑ Yes ❑ No

If so, **Please provide additional details:**

_____

_____

Additional Information

Preferred Language *(Select One)***:**

❑ English ❑ Spanish ❑ Other: _____

Religion *(Optional)***:** _____

Emergency Contacts

Parent/Guardian *(if 18 or older, please list Primary Contact)*

Name: *(First, Middle, Last)*: _____

Relationship to Patient: _____

Home Phone: _____ **Cell Phone:** _____

Additional Contact 1:

Name: *(First, Middle, Last)*: _____

Relationship to Patient: _____

Home Phone: _____ **Cell Phone:** _____

Additional Contact 2:

Name: *(First, Middle, Last)*: _____

Relationship to Patient: _____

Home Phone: _____ **Cell Phone:** _____

Additional Information

Communication Preference *(Select One)*:

❑ Home Phone ❑ Cell Phone ❑ Email ❑ Mail

If Cell Phone, **who is your network provider?** _____

Pregnant? ❑ Yes ❑ No … If so, **Lactating?** ❑ Yes ❑ No