



PATIENT INFORMATION	PRIMARY POLICYHOLDER'S INFORMATION
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NAME	NAME
SS#	DATE OF BIRTH
STREET ADDRESS	SS#
MAILING ADDRESS COUNTY	PHONE #
CITY & STATE ZIP	

POLICYHOLDER'S EMPLOYER INFORMATION	
PHONE CELL PHONE	EMPLOYER
DATE OF BIRTH	STREET ADDRESS
SEX: RACE: MARITAL STATUS:	MAILING ADDRESS

PATIENT'S EMPLOYER INFORMATION
CITY & STATE ZIP
EMPLOYER
STREET ADDRESS
MAILING ADDRESS
CITY & STATE ZIP
WORK PHONE #
FULL TIME [] PART TIME []

POLICYHOLDER'S MAILING ADDRESS (IF DIFFERENT)
ADDRESS
CITY & STATE
ZIP
PHONE #

PERSON RESPONSIBLE FOR BILL/GUARANTOR	SECONDARY POLICYHOLDER INSURANCE
NAME	PATIENT'S RELATIONSHIP TO POLICYHOLDER
SS#	NAME
STREET ADDRESS	DATE OF BIRTH
CITY & STATE	SS#
ZIP	PHONE #
PHONE #	

IF PATIENT IS A MINOR

MY CHILD _____ HAS MY PERMISSION TO BE TREATED IN MY ABSENCE AT SRHS Regional Physicians Network. I APPOINT _____ TO ACCOMPANY MY CHILD FOR MEDICAL TREATMENT IN MY ABSENCE

EMERGENCY CONTACT

NAME	HOME PHONE #:
RELATIONSHIP	WORK PHONE #:

PREFERRED METHOD OF CONTACT

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at our Regional Physician's Network? Okay to leave message on answering machines Y N (PLEASE CHECK ONE)

ANY METHOD:	HOME PHONE:	WORK PHONE:	CELL PHONE:
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RELEASE

I DO NOT AUTHORIZE ANY INFORMATION TO BE DISCLOSED TO ANY OTHER PARTIES EXCEPT TO ME AS THE PATIENT.

INITIAL HERE _____

NAME/RELATIONSHIP	PHONE:	NAME/RELATIONSHIP	PHONE:
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I AUTHORIZE THE PERSON(S) LISTED BELOW TO RECEIVE ALL HEALTH INFORMATION ABOUT APPOINTMENTS, TREATMENT &/or OTHER INFORMATION PERTINENT TO MY HEALTHCARE &/or PAYMENT FOR MY HEALTHCARE PROVIDED AT Regional Physicians Network:

PATIENT SIGNATURE

DATE