Horizon Healthcare
An Affiliate of
Fairfield Memorial Hospital

PATIENT REGISTRATION FORM

Please present Driver's License & Insurance Cards for Copy

213 NW 10th Street, Suite A
Fairfield, IL 62837
Ph 618-8424617
Fax 618-842-4743

PATIENT INFORMATION:

Legal Name _____ Maiden Name: _____
FIRST MIDDLE LAST

Social Security Number _____ Date of Birth _____ Age: _____ Birth Sex: ◯Male ◯Female

Gender Identity: ◯ Male ◯ Female ◯Other:_____ Sexual Orientation: ◯ Straight ◯Homosexual ◯Other:_____

Address _____ City _____ St _____ Zip _____

◯ Home Phone _____ ◯ Cell Phone _____ ◯Work Phone _____

(***Please check your preferred phone)***

Email Address: _____ (***we will not share this with other entities***)

Primary Insurance Company Name:_____

Secondary Insurance Company Name:_____

Preferred Language:
__ English __Spanish __French __Chinese __Other

Ethnicity:
__Hispanic or Latino __Non-Hispanic or Latino

Religious Preference _____ (if none, please write N/A) **Race:** _____

Marital Status
__Single __Married __Domestic Partner __Life Partner __Divorced __Separated __Widow __Minor

Do you have any Advanced Directives: __Yes __No **If 'Yes', please provide us with a copy of Advanced Directives.**

Do you have any hearing or vision impairment (other than hearing aids or glasses): __No __Yes, hearing __Yes, vision
Explain: _____

EMPLOYER: _____

GUARANTOR INFORMATION: (*Complete this section if patient is a minor, or if someone other than patient is responsible for charges not paid by insurance*)

***Parent or Legal Guardian's Name**:* _____
Relationship to patient: _____ *Parent/Guardian's Date of Birth:* _____
Same address as patient? __ Yes __ No Phone Number: _____
If no, please provide address: _____

***Other Parent or Legal Guardian's Name**:* _____
Relationship to patient: _____ *Parent/Guardian's Date of Birth:* _____
Same address as patient? __ Yes __ No Phone Number: _____
If no, please provide address: _____

HAVE YOU COMPLETED A "WHEN YOU'RE NOT THERE" FORM? __YES __ NO
If NO, please ask your customer service representative for a form.

EMERGENCY CONTACT FOR PATIENT:
Name: _____ Relationship:_____ Phone: _____

Secondary Contact/Support Role: Name _____ Relationship_____ Phone_____

If any of the information above changes, please notify us in a timely manner. *If patient is unable to sign and you are Healthcare Power of Attorney or Legal Guardian, you must provide us with legal documentation for our records*. If applicable, please provide us with a copy of Advanced Directives as well.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

REV 04/2021