****PLEASE PRINT - COMPLETE BOTH PAGES****

MICHIGAN STATE UNIVERSITY HEALTHTEAM

MRN _____
(For office use only)

PATIENT REGISTRATION

Date _____

PATIENT INFORMATION

Patient Name _____ SS# _____
Last First M.I.

Age _____ Date of Birth _____ Male Female Marital Status _____ Email _____

Race (circle one) African-American, American Indian or Alaska Native, Asian, Pacific Islander, Other, Decline to Answer

Ethnicity (circle one) Hispanic or Latino, Not Hispanic or Latino, Decline to Respond

Preferred Language _____

Address _____
Street/Apt # City State Zip Code

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Employer's Address _____
Street City State Zip Code

MSU Student? Yes No If Yes, Student # _____ MSU Athlete? Yes No

Emergency Contact Person #1 _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact Person #2 _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Primary Care Physician _____ Telephone _____

Address _____
Street City State Zip Code

Referring Provider (if not PCP) _____ Telephone _____

Address _____
Street City State Zip Code

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment _____
Last First M.I.

Date of Birth _____ SS# _____ Relationship to Patient _____

Address – **Same as Patient** ☐ _____
Street/Apt # City State Zip Code

Phone: Home _____ Work _____ Cell _____

Employer _____ Address _____
Street City State Zip Code

Other Parent's Name _____ Date of Birth _____
Last First M.I.

Other Parent's Address – **Same as Patient** ☐ _____
Street/Apt # City State Zip Code

Other Parent's Phone: Home _____ Work _____ Cell _____

INSURANCE INFORMATION

INSURANCE PLAN _____ Effective Date _____ Primary ____ Secondary ____

Insurance Plan Address _____

Insurance Plan Phone# _____ Auth/Precert Phone# _____ Customer Service Phone# _____

Name of Policyholder _____ Date of Birth _____ Gender _____

Employer & Address _____

SSN _____ Relationship to Patient _____

Policyholder Address/Phone # _____

Contract/ID/Group # _____ Service Plan # _____ Coverage Type _____

Primary Care Copay _____ Specialty Copay _____ Mental Health Copay _____ PT/SP/OT Copay _____

INSURANCE PLAN _____ Effective Date _____ Primary ____ Secondary ____

Insurance Plan Address _____

Insurance Plan Phone# _____ Auth/Precert Phone# _____ Customer Service Phone# _____

Name of Policyholder _____ Date of Birth _____ Gender _____

Employer & Address _____

SSN _____ Relationship to Patient _____

Policyholder Address/Phone # _____

Contract/ID/Group # _____ Service Plan # _____ Coverage Type _____

Primary Care Copay _____ Specialty Copay _____ Mental Health Copay _____ PT/SP/OT Copay _____

WORKERS COMPENSATION/AUTO LIABILITY _____Primary _____Secondary Authorization Required? Yes No

Carrier _____ Case/Claim # _____

Claims Address _____

Phone # _____ Contact Person _____