First Choice
Home Health • Hospice • House Calls

First Choice House Calls
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Patient Registration Form

Patient Information

Last Name:	First Name:	Previous Name (if applicable)
Facility:	Address:	
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred method of contact for reminder calls and other electronically generated messages: (Please select only one option) ☐ Voice ☐ Text		If Voice, please select preferred number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	○ Male ○ Female	Family Physician or Pediatrician:
Marital Status:	Social Security #:	
Emergency Contact Name:	Emergency Contact Phone #:	
Alternative Contact Name and Phone Number:		Relationship to Patient:

Additional Information and Responsible Party

PERSON RESPONSIBLE FOR THE BILL ○ Self ○ Other (IF OTHER PLEASE FILL OUT COMPLETELY)

Last Name:		First Name:
Date of Birth:	Phone:	Relationship to Patient:

ADDITIONAL INFORMATION (please fill out all sections below)

Email Address:

Can we leave a message regarding your medical care & test results? ○ Yes ○ No

PREFERRED PHARMACY:
Name and location:

RACE (please select):
○ White ○ American Indian or Alaska Native ○ Asian
○ Hispanic ○ Black or African American ○ Native Hawaiian or Pacific Islander
○ Other ○ Decline

ETHNICITY (please select one):
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline

PREFERRED LANGUAGE (please check one): ○ English ○ Spanish ○ Other

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
ID Number:	ID Number:
Group Number:	Group Number:

☐ Primary Care ☐ Urgent Care ☐ Transitions ☐ Face to Face ☐ Physician Support ☐ Palliative Care