Sioux Center Health
An Avera Partner

PATIENT REGISTRATION FORM

Sioux Center Medical Clinic
1101 9th St SE
Sioux Center, IA 51250
(712) 722-2609
Fax: (712) 722-8426

Hull Medical Clinic
807 Main St. Suite D
Hull, IA 51239
Phone (712) 439-1315
Fax: (712) 439-1264

PATIENT INFORMATION

Legal Last Legal First Legal Full Middle

Date of Birth (Mo/Day/Yr) Sex (M/F)

Social Security Number

Maiden or Other Name

Mailing Address

City State Zip

( )
Home Phone

( )
Cell Phone

Email Address

Employer

Mailing Address

City State Zip

Occupation

( )
Work Phone

Employment Status: ☐ Part-time ☐ Full-time ☐ Retired

Your Primary Care Physician

Primary Care Physician's Clinic Name (if not SCCH)

Above Clinic Location (City)

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow(er)
- ☐ Other
- ☐ Unknown

Race
- ☐ White
- ☐ Unknown
- ☐ Hispanic or Latino
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Hawaiian/Other Pacific Islander
- ☐ Asian
- ☐ Choose not to disclose/Declined

Preferred Language

Do you have a Living Will? Y N Unsure Like more info

Power of Attorney? Y N Unsure Like more info

If yes, Who:

NEXT OF KIN:

Last First Full Middle

Address

City State Zip

( ) ( )
Home Phone Other phone

Relationship to you (the patient)

PERSON TO NOTIFY IN AN EMERGENCY:

Last First Full Middle

Address

City State Zip

( ) ( )
Home Phone Other phone

Relationship to you (the patient)

FINANCIAL RESPONSIBLE PARTY INFORMATION

If same as patient, write same on name line, and proceed to insurance section.

Last First Full Middle

Date of Birth (Mo/Day/Yr) Sex (M/F)

Social Security Number

Mailing Address

City State Zip

( )
Home Phone

Relationship to you (the patient)

Employer

Mailing Address

Mailing Address

City State Zip

Occupation

( )
Work Phone

Employment Status: ☐ Part-time ☐ Full-time ☐ Retired

If this visit should be billed to someone other than you/your health insurance, please inform the receptionist.

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

Name of Insurance Company

Name of Subscriber

Subscriber's SSN DOB

Policy Effective Date

Relationship to you (the patient)

SECONDARY INSURANCE POLICY

Name of Insurance Company

Name of Subscriber

Subscriber's SSN DOB

Policy Effective Date

Relationship to you (the patient)

WIRELESS COMMUNICATIONS:

I hereby agree that by providing my cell/wireless phone number, I am granting my consent to receive automatic dialing calls on my cell/ wireless phone number for any billing, accounting, collection or other financial contact. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

☐ Decline

RELEASE OF INFORMATION

I authorize the release of medical and/or billing information to the following family members.
(If none, write none on the first blank line.)

AUTHORIZATION FOR TREATMENT

I hereby consent to the Sioux Center Health Physicians, Mid-levels and staff for medical treatment, diagnostic and/or surgical procedures.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all payments for medical/surgical services rendered by Physicians including Medicare, private insurance, and other healthcare coverage to Sioux Center Health Medical Clinics. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including any amount not covered by my insurance company.
I authorize Sioux Center Health Medical Clinics to furnish medical information necessary to process insurance claims for me and/or my covered dependents.

Your Signature Date