# HEALTH CENTRAL PRE REGISTRATION FORM

**Patient Information:**
Name: ___________________________________
Address: _________________________________
City, State, Zip :___________________________
Phone: ___________________________________
SS#: _____________________________________
DOB: ____________Race: __________________
Marital Status: ________________Sex: _______
Email____________________________________

**Guarantor Information (If not patient):**
Name: ____________________________
Address: __________________________
City, State, Zip: ____________________
Phone: ____________________________
SS#: ______________________________
DOB: _____________Race: __________
Marital Status: ___________Sex: ______
Relation to Patient: _________________

**Patient Employer Information:**
Name: ___________________________________
Address: _________________________________
City, State Zip: ____________________________
Phone: _________________________________
Full Time { } Part Time { }
Retired? ___________ Date ________________
Disabled? __________ Date ________________
Self Employed? Yes { } No { }
Student: Yes { } No { }

**Emergency Contact Information:**
Name: ____________________________
Address: __________________________
City, State, Zip: ____________________
Phone: ____________________________
Alternate Phone: ___________________
Relation to Patient: _________________

**Primary Insurance Information:**
Name: _________________________________
Cust. Svc. Phone: ________________________
Claims Address: _________________________
Policy # _______________________________
Group # _______________________________
Precert Required? Yes { } No { }
(If unknown, please call ins. to find out.)

**Insured Person:** If not Self { }
Name: ____________________________
SS#: ______________________________
DOB: ______________Sex:___________
Relation to Patient: _________________
Employer: _________________________
___________________________________

**Secondary Insurance Information:**
Name: _________________________________
Cust. Svc. Phone: ________________________
Claims Address: _________________________
Policy # _______________________________
Group # _______________________________
Precert Required? Yes { } No { }
(If unknown, please call ins. to find out.)

**Insured Person:** If not Self { }
Name: ____________________________
SS#: ______________________________
DOB: ______________Sex:___________
Relation to Patient: _________________
Employer: _________________________
___________________________________

If Military: Branch _______________ Status: ______________ Pay Grade: ______________

- Procedure ________________________________Diagnosis: ____________________________
  Ordering Doctor: _____________________________________
- Appointment Date ___________________ Time: _____________________
- We may need to call you for additional information in order to complete the Pre Registration Process.
- Form may be submitted online or faxed to 407-253-1677.

5/04-sdb