****PLEASE PRINT - COMPLETE BOTH SIDES****

MRN _____
(For office use only)

**PATIENT REGISTRATION**

MSU HealthTeam
*Our specialty is you*

Date _____

## PATIENT INFORMATION

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

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

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 _____

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**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 _____

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**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 _____

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**WORKERS COMPENSATION/AUTO LIABILITY** _____ Primary _____ Secondary Authorization Required? Yes ☐ No ☐

Carrier _____ Case/Claim # _____

Claims Address _____

Phone # _____ Contact Person _____

Date of Injury/Accident _____

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