Kettering Medical Center Network

THIS FORM TO BE COMPLETED BY MALE ONLY

Pre-Registration

*Please Print *

Patient's Name: ______________________________ Date of Birth: __________
First Middle Int. Last Month/Day/Year

Address: ______________________________

City/State/Zip: ______________________________
Home phone: ( ) ______________ Business phone: ( ) ______________
Cell phone: ( ) ______________ Pager number: ( ) ______________
Patient's Social Security Number: ______________ Marital Status: ______________
(e.g.: married/divorced/widowed/single)
Employer: ______________ Occupation: ______________
(if retired, where did your retire from?) (e.g.: homemaker,clerical,engineer, retired, etc.)
May we contact you at work? Y / N May we leave a message at: Home ___ Work ___ Both ___
(Please circle one) (Please check one)
Name of Spouse (if married or separated): ______________ Date of Birth: __________

Spouse's Employer: ______________ Occupation: ______________
(if retired, where did your retire from?) (e.g.: homemaker,clerical,engineer, retired, etc.)

Who to notify in case of emergency:
Name: ______________ Home phone: ( ) ______________
Relationship: ______________ Alt phone: ( ) ______________
Secondary notification:
Name: ______________ Home phone: ( ) ______________
Relationship: ______________ Alt phone: ( ) ______________

Insurance information: ***(Send copy of insurance card)**
1) **Name of Primary Insurance**: ______________
Name of subscriber for this insurance: ______________ Relationship: ______________
Name of employer: ______________
ID or Member Number on insurance: ______________ Group #: ______________
Insurance Address (where to send claim) ______________
______________ Insurance Benefit phone number: ( ) ______________
(City/State/Zip)
2) **Name of Secondary Insurance**: ______________
Name of subscriber for this insurance: ______________ Relationship: ______________
ID or Member Number for this insurance: ______________ Group #: ______________
Insurance Address (where to send claim) ______________
______________ Insurance Benefit phone number: ( ) ______________
(City/State/Zip)

Name of family physician: ______________
Religious preference: ______________
(e.g.: Catholic, Jewish, Mormon, no preference, none, etc.)