HILL COUNTRY MEMORIAL
PRE-REGISTRATION
PATIENT INFORMATION

PLEASE PRINT

Patient Name:_____

Mailing Address:_____

City/State/Zip:_____

Cell Phone/Home Phone#:_____

E-mail Address:_____
Would you like access to your medical records online? YES / NO

Would you like anyone to have access to your medical records? YES / NO

Name_____**Relation**_____

Social Security #: _____

Marital Status: (CIRCLE ONE) **SINGLE/MARRIED/WIDOWED/DIVORCED/LEGALLY SEPARATED**

Name of primary doctor: _____
Religious preference:_____
Race/Ethnicity:_____
Occupation:_____
Employer:_____

Are you a US citizen? Y / N
Have you ever served in the military? Y/N
Do you have an Advanced Directive, Living Will, Or POA? Y/N
Do you want further information on an advance directive, living will, or POA? Y/N

First emergency contact

Name: _____
Address: _____
City/State/Zip : _____
Home/Cell Phone: _____
Relationship to Patient:_____

Next of Kin or Alternate person to notify in case of emergency

Name: _____
Address: _____
City/State/Zip: _____
Home/Cell Phone: _____
Relationship to Patient:_____

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INSURANCE: Please fill out completely even if copies of your insurance cards were provided.

Primary Medical Insurance

Name: _____

Phone: _____

Policy ID:_____ Group #:_____ Subscriber: Self/ Other

If Subscriber is someone other than patient:

Name:_____

Subscriber's birthdate: _____

Subscriber's SSN: _____

Subscriber's relationship to patient? Spouse/ Mother/ Father/ Other _____

Secondary Medical Insurance

Name: _____

Phone: _____

Policy ID:_____ Group #:_____ Subscriber: Self/ Other

If Subscriber is someone other than patient:

Name:_____

Subscriber's birthdate: _____

Subscriber's SSN: _____

Subscriber's relationship to patient? Spouse/ Mother/ Father/ Other _____

I certify that the above information is accurate and complete.

Signed_____ **Date**_____