RGH Patient Information Sheet

Hospital / Emergency Room / OP Services

Completed by ER Tech:
◯ Pt. Unable to Provide Any Information
◯ No Insurance Information Provided
◯ No Photo ID Provided
◯ RGH Billing Department Information Provided
◯ Pt. INCARCERATED - PRIVATE PAY
◯ Quick Register After Hours

Patient Information

Last Name_________________________________First Name_______________________________ MI_____

Physical Address _____________________________________City ______________State______ Zip_______

Home Phone______________________ Cell Phone _______________________ County_________________

Date of Birth___________________ Gender__________ Primary Language___________________________

Race (choose one): ◯White ◯Asian ◯Black/African American ◯American Indian/Alaskan native ◯Native Hawaiian/Pacific Islander ◯Other/Unknown/Declined to Specify

Ethnicity (choose one): ◯Hispanic/Latino ◯Non-Hispanic ◯Declined to Specify ◯Unknown

Guarantor

Responsible Party ____ Relationship to Patient_______________

***Mailing Address* ________________________________ *City* ________________ *State*_______ *Zip*________**

Date of Birth_____________ Home/Cell Phone____________________ Work Phone___________________

Emergency Contact Information

Name____ Relationship to Patient_________________

Home/Cell Phone______________________________ Work Phone___________________________________

Primary Care Provider____

Facility____ Phone_______________________________

Insurance

◯***Check if photocopy of Insurance Card complete***

Primary Insurance Carrier____________________________ Address__________________________________

Subscriber Name______________________________________ Relationship to Patient__________________

Member ID____ Group Number___________________________

Please note, 2nd page on back

Revised 02/22/2021

Workers Compensation Carrier

Motor Vehicle Insurance Information

◯ ***Check if Medical Care sought due to work related injury***

◯ ***Check if involved in a Motor Vehicle Accident***

Insurance Company Name____Phone__________________

Address____ City _______________ State________ Zip_______

Claim Number__________________________________ Contact Person_____________________________

Date of Injury___________ Subscriber Name______________________ Relationship to Patient__________

Employer

Employment Status ◯Employed ◯Self-employed ◯Retired ◯On active military duty ◯Unknown

Employer Name____

Employer Address ____ Phone______________________

Signature

I verify that the above information is factual and true to the best of my knowledge. I understand that proof of insurance and/or copay, if applicable, is due at the time of service.

Patient or Legal Guardian Signature_______________________________________ Date________________

Patient Portal Information

Email Address____

Mother's Maiden Name____

*** The Rio Grande Hospital patient portal allows patients to access health information electronically.*
Email address and mother's maiden name are necessary pieces of information to access your portal account