HOSA Medical Office Registration Form (Simulated Electronic Health Record)

Competitors will open, in step #5, this simulated Electronic Health Record page that is saved in printable PDF format to fill in on the computer using the handwritten HOSA Medical Office Registration form.

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (Check one) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.:

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Insurance Company

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HOSA Medical office or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*