UVA Health

Karen S. Rheuban Center for Telehealth

Patient Registration Form

Date: _____

Name: Last: _____ First: _____ Middle: _____ Suffix: _____

Maiden: _____ Age: _____ Date of Birth: _____

Home Phone Number: _____ Sex: M F Social Security Number: _____

Alternate Phone Number: _____, [ ] cell [ ] work

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Marital Status: Married Single Divorced Separated Widowed

Race: Asian Black or African American Hispanic Native American White / Caucasian

Other _____

Employment Status: Full time Part time Unemployed Retired Student Other: _____

Patient Occupation: _____ Patient's Employer: _____

Employer Address: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____ Address: _____

GUARANTOR INFORMATION (If other than patient) **- Provide copy of ID**

Guarantor Name: _____ Relationship to Patient: _____

Phone Number: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Guarantor Employer: _____ Work Phone Number: _____

Employer Address: _____

INSURANCE INFORMATION - Provide copy of insurance card(s), front and back

Primary Insurance: _____ Phone Number: _____

Claim Address: _____

Policy ID #: _____ Group Name/#: _____

Subscriber Name: _____ Relationship to Patient: _____

Phone Number: _____ Address: _____

Date of Birth: _____ Sex: M F Social Security Number: _____

Subscriber Employer: _____ Work Phone Number: _____

Employer Address: _____