



# HILL PARK MEDICAL CENTER PATIENT REGISTRATION FORM

MEDICAL CENTER

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

SSN#: \_\_\_\_\_

I am:  Married  In a Partnership  Separated  Divorced  Widowed  Single

I live with:  Spouse  Partner  Parents  Children  Friends  Alone

Occupation: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

Name of Spouse/Parent: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How did you hear about Hill Park Medical Center? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices: \_\_\_\_\_  
*signature*

I have elected not to receive a copy of the Notice of Privacy Practices: \_\_\_\_\_  
*signature*