Essentia Health Registration Form

PATIENT INFORMATION:			
Last Name:		First Name:	
Middle Name:		Maiden/Other:	
Birthdate:	Sex: ☐ M ☐ F	Social Security Number:	
Home Phone:	Cell Phone:	Other Phone:	
Address:	City:	State:	Zip:
Have you ever registered at any EH facility under any other name?	☐ Yes ☐ No	What Name?	
Employer:	Occupation:	Employer's Phone:	
Employer's Address:	City:	State:	Zip:

PERSON TO NOTIFY (In Case of Emergency)			
Name:	Relationship:	Phone:	
Address:	City:	State:	Zip:

PERSON ULTIMATELY RESPONSIBLE FOR BILL IF DIFFERENT FROM PATIENT (Guarantor/Responsible Party)			
Name:	Relationship:	Phone:	
Address:	City:	State:	Zip:

PRIMARY INSURANCE		
Insurance Company Name:	Insurance ID #:	Group #:
Policy Holders Last Name:	First Name:	Middle Name:
Birthdate:		

SECONDARY INSURANCE		
Insurance Company Name:	Insurance ID #:	Group #:
Policy Holders Last Name:	First Name:	Middle Name:
Birthdate:		