OUTPATIENT REGISTRATION FORM

All bolded items must be completed, or a complete demographic form must be attached.

Ordering Provider						
Patient Name (Last, First, Middle Initial)					**Diagnosis/Chief Complaint**	
Patient Social Security Number	**Birthdate**	**Age**	**Sex**	**Marital Status**	**Telephone #**	**Street Address**
Mailing Address					**City, State, Zip code**	
Patient Employer	**Primary Care Provider**					

Responsible Party	Relationship to Patient	Responsible Party Social Security No.	Telephone Number
Street Address	Mailing Address	City, State, Zip	
Employer	Address		Employer Telephone

1 Primary Insurance	**Insurance Mailing Address (Include City, State, and Zip)**	
Group Through What Employer	**Group #**	**Policy #**
Policy Holder's Name	**Policy Holder's Birthdate**	**Policy Holder's Social Security Number**
2 Secondary Insurance	Insurance Mailing Address (Include City, State, and Zip)	
Group Through What Employer	Group #	Policy #
Policy Holder's Name	Policy Holder's Birthdate	Policy Holder's Social Security Number

IF WORKMAN'S COMPENSATION	Date of Injury	Occupation	Length of Service with Employer

______ **CONSENT TO TREATMENT:** Diagnostic/Out-Patient Authorization: The undersigned consents to any x-ray examination, laboratory procedures, respiratory therapy procedures, physical therapy treatment rendered the patient under the general and special instructions of his physician(s).

______ **RELEASE OF INFORMATION:** I hereby authorize Memorial Hospital of Sweetwater County to disclose information from the Medical Record to any person or corporation which is or may be liable under a contract to the hospital or to the patient or to a family member or employer of the patient for all or part of the hospital's charge including but not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare employer any funds, the patient's health care or extended care facility that I may be transferred to in the even it is deemed appropriate to make such transfer.

ASSIGNMENT OF BENEFITS: I hereby assign payment of insurance benefits to Memorial Hospital of Sweetwater County, P.O. Box 1359, Rock Springs, Wyoming, 82902. I understand that I am financially responsible to the hospital for full payment within 60 days after discharge. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied to any other account owed to the hospital by the insured or his/her family.

PATIENT: ______________________ **or NEAREST RELATIVE:** ______________________

WITNESS: ______________________ **RELATIONSHIP TO PATIENT:** ______________________

DATE: ______________________ **TIME:** ______________________ **AM / PM**

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