Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

PATIENT REGISTRATION FORM

Complete all information requested below. Without this information, it will not be possible to arrange the appointment(s) you are requesting. Once complete, please send via fax to 305-355-5545 or email to JacksonFirstConcierge@jhsmiami.org , include copies of your insurance card (front and back), and all pertinent medical reports and records.

Please Note: If you are experiencing symptoms that are urgent in nature please contact your primary care physician or your nearest urgent care facility.

Today's Date:

PATIENT INFORMATION (PLEASE PRINT)

Patient's Last Name: **First:** **Middle Initial:**			Marital Status: S ☐ M ☐ D ☐ W ☐	Sex: M ☐ F ☐
Date of Birth: ***(mm/dd/yyyy):***	**Age:**	**Social Security #:**	**Primary Language:**	
Parent's Date of Birth *(if patient under **18**):* ***(mm/dd/yyyy):***				
Permanent Address (*Include city, state, zip*):				
Permanent Telephone # :			**Fax #:**	
Email Address:		**Cell Phone #:**		
Occupation:		**Employer:**	**Employer's Phone #:**	
Contact Person and Phone # in Case of Emergency:			**Relationship to Patient:**	

INSURANCE INFORMATION (PLEASE PRINT)

Do you have health insurance that will cover your services at Jackson Health System? Yes ☐ No☐	**Insurance Company:**	
Subscriber's Name:	**Subscriber's Social Security #:**	
Subscriber's Date of Birth: ***(mm/dd/yyyy):***	**Insurance Policy #:**	**Group #:**
Insurance Company Address ***(Must be an address in the United States):***		
Insurance Phone #: ( )	**Patient's relationship to subscriber:** Self ☐ Spouse ☐ Child ☐ Other☐	

APPOINTMENT REQUEST (PLEASE PRINT)

Primary Diagnosis or Medical Condition which brings you to Jackson Health System?

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Are you ambulatory Yes ☐ **No** ☐

Appointment date requested:

1st Choice

2nd Choice

Please list any physical disabilities

_____

_____

_____

_____

If known, what physician(s) or specialist(s) would you like to see?

_____

_____

REMINDER: Please include the following documents with your registration:

- **Copy of Photo ID (i.e. license, passport, etc…)**
- **Medical Reports and/or Results**
- **Copy of Insurance card (Front and back)**