☐ SCHS Caregiver Exposure

St. Charles HEALTH SYSTEM

St. Charles Patient Laboratory Registration Form

If we are unable to verify insurance, we will be calling the responsible party for additional information. For Medicare MSP information we will call to obtain this required information, if appropriate for secondary insurance listed.

PATIENT / SPECIMEN INFORMATION				
PATIENT LAST NAME	FIRST NAME, MI	SSN		
ADDRESS	CITY /STATE / ZIP CODE			
HOME PH#	WORK PH# & EXT	CELL PH#	SEX	DATE OF BIRTH
EMPLOYER	E-MAIL			
PRIMARY CARE PHYSICIAN	MARITAL STATUS			
EMPLOYMENT STATUS	STUDENT STATUS	RELATIONSHIP TO RESPONSIBLE PARTY		

ONLY IF DIFFERENT FROM PATIENT ACCOUNTS / RESPONSIBLE PARTY INFORMAITON				
PATIENT LAST NAME	FIRST NAME, MI	SSN		
HOME PH#	WORK PH# & EXT	CELL PH#	SEX	DATE OF BIRTH
ADDRESS (IF NOT SAME AS PATIENT)	CITY /STATE / ZIP CODE			
SSN	EMPLOYER	E-MAIL		

DO YOU HAVE INSURANCE: YES or NO IF YES, ENTER INSURANCE INFORMATION BELOW

1	INSURANCE CARRIER NAME	CARRIER ADDRESS		
	CERTIFICATE ID NUMBER	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE NO.
	SUBSCRIBER NAME	SUBSCRIBER DOB	SUBSCRIBER SSN	RELATIONSHIP TO
2	INSURANCE CARRIER NAME	CARRIER ADDRESS		
	CERTIFICATE ID NUMBER	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE NO.
	SUBSCRIBER NAME	SUBSCRIBER DOB	SUBSCRIBER SSN	RELATIONSHIP TO

EMERGENCY CONTACT INFORMATION			
LAST NAME	FIRST NAME	DATE OF BIRTH	
HOME PH#	WORK PH#	CELL PH#	RELATIONSHIP TO PATIENT

ADDITIONAL INFORMAITON		
RACE	ETHNICITY	LANGUAGE
INTERPRETER NEEDED	NAME YOU GO BY	