# HOSA Medical Office Registration Form (Simulated Electronic Health Record)

Competitors will open, in step #5, this simulated Electronic Health Record page that is saved in printable PDF format to fill in on the computer using the handwritten HOSA Medical Office Registration form.

| Today's date: | PCP: |
|---|---|

## *PATIENT INFORMATION*

| Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (Check one) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid |
|---|---|---|---|---|---|

| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: |
|---|---|---|

Other family members seen here:

## *INSURANCE INFORMATION*

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: |
|---|---|---|---|

| Occupation: | Employer: | Employer address: | Employer phone no.: |
|---|---|---|---|

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Insurance Company

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

## *IN CASE OF EMERGENCY*

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HOSA Medical office or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*