Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

NEW PATIENT REGISTRATION FORM *Date:*_____

Patient Information

Name:	Sex: Male Female Unknown
DOB:	Social Security #:
Marital Status:	Religion:
Phone:	Employer:
Email:	Employer Phone #:
Address:	Employer Address:
Preferred Method of Contact: Telephone Email Letter	

Guarantor Information

Name:	Patients Relation:
DOB:	Sex: Male Female Unknown
Phone:	Address:
Employer:	

Emergency Contact Information

Primary Contact:	Relation to Patient:
Phone:	Address:
Sex: Male Female Unknown	

Insurance Information

Subscriber Name:	Insurance Name:
Relation to Patient:	Policy #:
DOB:	Group #:
Sex: Male Female Unknown	Phone #:

Subscriber Name:	Insurance Name:
Patients Relation:	Policy #:
DOB:	Group #:
Sex: Male Female Unknown	Phone #:

Encounter Information

Provider:	Reason for visit:
Appointment Time:	Registration Time:
Accident related visit: Yes No	Work related Accident: Yes No
Type of Accident:	State Accident occurred: VT NH Other:____
Amount Paid: $	MC Visa Check Cash