Sentara®

Prelude Physician Practices

Patient Registration Form

Visit Information

Private Encounter: Yes No **Accident Related:** Yes No **Financial Assistance**: Yes No

Patient Demographics

Last Name: _____ First Name: _____ MI: _____

AKA (Also Known As) /Previous Last Name(s): _____

Social Security #: _____ Date of Birth: _____/_____/_____

Legal Sex: ☐ Male ☐ Female

Gender Identity: ☐ Choose Not to Disclose ☐ Female ☐ Male ☐ Nonbinary ☐ Other

☐ Transgender Female (Male-to-Female) ☐ Transgender Male (Female-to-Male)

Sex Assigned at Birth: ☐ Choose Not to Disclose ☐ Female ☐ Male ☐ Unknown

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Alternate Phone: ( ) _____ Alternate Phone Info: ( )_____

E-Mail: _____

General Information:

Marital Status: ___Married ___Single ___Divorced ___Legally Separated ___Widowed ____ Life Partner

Communication Needs: ☐ Yes ☐ No Needs Interpreter: ☐ Yes ☐ No

Language Preference (if other than English): _____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Pacific Islander or Native Hawaiian ☐ Other/Unknown

Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

☐ Unknown

Do you have an Advanced Care Plan? (Advance Directive, Living Will or Medical Power of Attorney):

☐ Yes ☐ No

Primary Care Provider Name: _____

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Emergency Contact: Name: _____ Relationship to Patient: _____
Phone: _____

Patient Employment: Employer: _____ Phone:_____

Employment Status: ☐ Full Time ☐ Not Employed ☐ Active Military Duty ☐ Part Time ☐ Retired
☐ Self-Employed ☐ Student-Full Time ☐ Student-Part Time

Additional Information:

Communication Preferences: ☐ No Preference ☐ Do not contact ☐ Mail ☐ Phone ☐ Text ☐ Email ☐ MyChart

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Guarantor Account (Person Financially Responsible for Account)

Who is responsible for this account? ☐ Self ☐ Employer ☐ Spouse ☐ Father ☐ Mother

Guarantor Information: (Complete this section if guarantor is anyone other than self)

Name: _____ SSN: _____ Legal Sex: ☐ Female ☐ Male

DOB: _____ Home Phone: _____ Work phone: _____

Guarantor Demographics:

Address: _____ City: _____

State: _____ Zip: _____ E-mail:_____

Guarantor Employment:

Employment Status: ☐ Not Employed ☐ Active Military Duty ☐ Full-Time ☐ Part-Time
☐ Self-Employed ☐ Retired ☐ Student Full-Time ☐ Student Part-Time

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Coverage Summary

Primary Insurance Information:

Plan Name: _____ Member ID: _____

Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

Policy Holder's SSN: _____ Group #: _____ Policy Holder's Date of Birth: ____/____/____

Secondary Insurance Information:

Plan Name: _____ Member ID: _____

Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

Policy Holder's SSN: _____ Group #: _____ Policy Holder's Date of Birth: ____/____/____