1800 21st Avenue South
Fargo, ND 58103
T: 701-365-8700
F: 701-365-8701

Registration Form

ID: ________________

Patient Information

Name:____

First Middle Last

Mailing Address:____

City: ____________________________ State: ________________ Zip:__________________

Permanent Address: ____

City: ____________________________ State: ________________ Zip:__________________

Home Phone (_____) _____________________ Cell Phone (_____) _____________________

Email address: ____

Birthdate: _____/_____/______ Age: _____ Sex: ☐ M ☐ F SSN: ______-_____-________

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Other Spouse Name: ______________________

Employer: ____

Work Phone (_____) _____________________ May we contact you at work: ☐ Y ☐ N

How did you hear about us? (Check the best answer.)

☐ Physician Referral ______________________ ☐ Patient Referral ______________________

☐ Staff ☐ Sign ☐ Billboard ☐ Internet ☐ Radio ☐ Phone Book

☐ Postcard ☐ TV ☐ Newspaper ☐ Newsletter ☐ Magazine ☐ Event

Emergency Contact

Name: ____Relationship:__________________

Home Phone (_____) _____________________ Cell Phone (_____) _____________________

Work Phone (_____) _____________________ Other (_____) _____________________

Preferred Contact

Our office will confirm your appointment 1 or 2 days prior to your appointment via TeleVox, an automated system.

I prefer to be contacted via:

☐ Home Phone ☐ Cell Phone (Call) ☐ Cell Phone (Text) ☐ Work Phone

Do we have permission to leave messages with a family member? ☐ Yes ☐ No

Do we have permission to leave a message on your answering machine? ☐ Yes ☐ No

☐ I do not want to receive any reminder messages.

Person Responsible for bill: (if other than patient & after insurance)

Responsible Party: ___________________________________ Relationship to Patient______________

Mailing Address: _______________________ City: ________________ State: _______ Zip: ________

SSN: ______-______-________ Birthdate: _____/_____/_______ Phone (_____)___________________

Employer: ______________________________________ Work Phone (_____) _________________

Spouse or other parent (if patient is a minor):__________________________________

Home (_____) ________________ Work (_____) _______________Cell (_____) ________________

*****If patient is 18 or over and making someone other than themselves the responsible party, they are authorizing Catalyst Medical Center to share financial information with the listed responsible party.**

Insurance Information

Catalyst Medical Center's policy is to have a copy of your current insurance card on file. In the event you do not have your card with you, your account will remain in self pay status until a copy of your current insurance card is received.

Insurance 1

Name of Insurance Company:____
Policy Holders Name: ____
Policyholders Birthdate: ____/____/_____ Policyholders SSN: ______-_____-________
Policyholders address: ____
City:_______________________ State:______________ Zip:___________________
Policyholders Phone # (______) ____________________
Policyholders ID #: _________________________ Group #_____________________
Policyholders Employer____
Relationship to Insured: _______________________

Insurance 2

Name of Insurance Company: ____
Policy Holders Name: ____
Policyholders Birthdate: ____/____/_____ Policyholders SSN: ______-_____-________
Policyholders address: ____
City:_______________________ State:______________ Zip:___________________
Policyholders Phone # (______) ____________________
Policyholders ID #: _________________________ Group #_____________________
Policyholders Employer____
Relationship to Insured: _______________________

Your signature verifies that the information provided is accurate to the best of your knowledge.

_____________________________________ ____________________________

Patient Signature / Legal Guardian Date