St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177

Tel: (340)775-3700
Fax: (340)777-7927

"Your Health is our First Priority"

PATIENT REGISTRATION FORM

Date:_____

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other Language other than English

Race ☐ Black African American ☐ American Indian/ Alaska Native ☐ Asian ☐ Pacific Islander ☐ White

Ethnicity ☐ Hispanic/ Latino ☐ Non- Hispanic/ Latino ☐ Native Hawaiian

Mailing Address

Home Address | **Apt#** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Cell Phone**

Email Address | **Employment Status** ☐ Full Time ☐ Not Employed ☐ Student Full- Time ☐ Part- Time ☐ Retired ☐ Student Part- Time

Employer | **Employer Phone #**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (if self, Skip to Emergency Contact) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security**

Home Address | **Apt#** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Cell Phone**

Email Address | **Employment Status** ☐ Full Time ☐ Not Employed ☐ Student Full- Time ☐ Part- Time ☐ Retired ☐ Student Part- Time

PAYOR INFORMATION

Payment Source Insurance ☐ Yes ☐ No

Name of Insured _____ Insured Date of Birth _____

Name of Insurance _____

Insurance ID# _____ Yearly Income $ _____

EMERGENCY CONTACT

Last Name | **First Name** | **Relationship to Patient**

Home Phone | **Work Phone** | **Cell Phone**

Home Address | **Apt#** | **City** | **State** | **Zip Code**

OTHER INFORMATION

Public Housing ☐ Yes ☐ No **Veteran** ☐ Yes ☐ No

Housing Choice Voucher Program Recipient ☐ Yes ☐ No **Homeless/ Street/ Doubling Up** ☐ Yes ☐ No

Patient Signature (or Authorized Person)_____

Date:_____