

1800 21st Avenue South
Fargo, ND 58103
T: 701.365.8700
F: 701.365.8701



Patient 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

Referring Dr or Referral Source: _____

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 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