

# Take One



The ExpressCare card is your answer to all those questions. Simply fill out the enclosed application today!



To get your ExpressCare card, fill out this form right now. It's your answer to all those questions.

Please print and complete the information below:  
(One form needed for each family member.)

Patient's Name (Last, First, MI) \_\_\_\_\_  
 Maiden Name (Last) \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_  
 Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Other # ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Religious Preference \_\_\_\_\_  
 Veteran Status \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Race \_\_\_\_\_ Hispanic Origin  Yes  No  
 Have you ever been a patient here before?  Yes  No

#### Employer

Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

#### Next of Kin

Name (Last, First, MI) \_\_\_\_\_  
 Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

#### Person to Notify (Emergency)

Name (Last, First, MI) \_\_\_\_\_  
 Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

#### Guarantor Information (Person responsible for account)

Name (Last, First, MI) \_\_\_\_\_  
 Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

#### Guarantor's Employer

Employer's Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

#### Insurance Information

**Primary Insurance** \_\_\_\_\_  
 Claim Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Claims Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
 Claim Address \_\_\_\_\_ PO Box \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Claims Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_

#### Advance Directive

Do you have a living will or advance directive?  Yes  No  
 Was advance directive implemented before 9/1/1999?  Yes  No  
 If No, do you want more information?  Yes  No

Please return the completed application to: Paris Regional Medical Center, Attn: Admitting, 820 Clarksville St., Paris, TX 75460  
 The ExpressCare card contains information to help speed up your registration process. Please be assured, the ExpressCare card does not contain any private medical information.  
 Some information will be verified on admission.