ENGLEWOOD HEALTH

ZT CORPORATE CONCIERGE PROGRAM

Patient Label

Patient Last Name (Print):_____ Patient First Name (Print):_____

Patient Date of Birth:_____ Patient Social Security Number: _____

Legal Sex: (Circle One) **MALE** or **FEMALE** Sex and/or Gender Identification: _____

Patient Address, City, State, Zip Code: _____

Relationship to ZT Systems employee: ☐ Self (employee) ☐ Spouse/partner ☐ Child

Home Phone:_____ Cell Phone: _____

Email Address:_____

Preferred Language: _____ Interpreter needed: (Circle One) **YES** or **NO**

Marital Status:_____ Religion: _____

Are you a Jehovah's Witness?: (Circle One) **YES** or **NO** If yes, do you Refuse Blood? (Circle One) **YES** or **NO**

Ethnicity: ☐ Central or South American ☐ Cuban ☐ Mexican or Mexican American or Chicano
☐ Not Spanish, Hispanic or Latino ☐ Other ☐ Other Spanish/Hispanic/Latino ☐ Puerto Rican
☐ Declined to answer

Race: ☐ American Indian ☐ Asian Indian ☐ Black or African-American ☐ Chinese ☐ Filipino
☐ Guamian/Chamorro ☐ Japanese ☐ Korean ☐ Multiracial - Black African Amer. & Amer. Indian or Alaskan
☐ Multiracial - White & American Indian/Alaskan Native ☐ Multiracial - White & Asian
☐ Multiracial - White & Black or African American ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Island
☐ Other Race ☐ Samoan ☐ Unknown/Unavailable ☐ Vietnamese ☐ White ☐ Declined to answer

Preferred PHARMACY (Name and location): _____

PCP (Primary Care Physician):_____

Employment Status:_____

Employer Name: _____

Employer Address, City, State, Zip Code: _____

_____

Employer Phone:_____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Primary emergency contact relationship to pt: _____

Primary emergency contact name: _____

Primary emergency contact sex:_____

Primary emergency contact address, city, state, zip: _____

_____

Primary emergency contact (2) phone numbers:_____ _____

Next of Kin? (Circle One) **YES** or **NO** Notify on Admission? (Circle One) **YES** or **NO**

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GUARANTOR INFORMATION (Person Responsible for the Patient Bill)

Is the patient also the guarantor? (Circle One) **YES** or **NO**

If not: _____

Guarantor's relationship to the patient: _____

Guarantor name: _____

Guarantor SS#:_____ Guarantor sex:_____

Guarantor DOB:_____

Guarantor address, city, state, zip:_____

_____

Guarantor phone #: _____ Guarantor cell #:_____

Guarantor's employment status: _____

Guarantor's employer: _____

Guarantor's employers address, city, state, zip: _____

_____

Guarantor's employer phone # _____

Guarantor's Occupation: _____

ENCOUNTER INFORMATION

Do you have an Advanced Directive? (Circle One) **YES** or **NO**

PRIMARY INSURANCE INFORMATION

Does the Patient have Insurance? (Circle One) **YES** or **NO**

Primary Insurance company name: _____

Patient's relationship to the subscriber: _____

Subscriber's name: _____

Subscriber DOB: _____ Subscriber Sex: _____

Subscriber SS#: _____ Policy #: _____

Group Name:_____ Group #:_____

ENGLEWOOD HEALTH

ZT CORPORATE CONCIERGE PROGRAM

Patient Label

PRIMARY INSURANCE INFORMATION (cont.)

Primary Insurance company address, city, state, zip: _____

_____

Primary Insurance company phone #:_____ Pre-cert #:_____

Subscriber employment status:_____

Subscriber employer: _____

Subscriber employer address, city, state, zip:_____

_____

Subscriber employer phone #: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance company name (if applicable):_____

Patient's relationship to the subscriber:_____

Subscriber's name: _____

Subscriber DOB: _____ Subscriber Sex: _____

Subscriber SS#: _____ Policy #: _____

Group Name: _____ Group #: _____

Secondary Ins company address, city, state, zip: _____

_____

Secondary insurance company phone #: _____ Pre-cert #: _____

Secondary Subscriber employment status: _____

Secondary Subscriber employer:_____

Secondary Subscriber employer address, city, state, zip: _____

Secondary Subscriber employer phone #:_____