CUMULUS HOSPITAL
123 Neon Way, Las Vegas, NV 89101 Patient Registration Form

I. PATIENT INFORMATION

Full Name: _____ Date of Birth (MM/DD/YYYY): _____Gender:_____Address:_____ _____City: _____ State: _____ Zip Code: _____Phone Number:_____ Email: _____

II. INSURANCE INFORMATION

Please provide your insurance details for coverage verification.

Insurance Provider: _____Policy Code:_____ Group Number (if applicable)_____

III. CONSENT AND AUTHORIZATION

I hereby authorize Cumulus Hospital to provide medical care and release information necessary for insurance claims. I acknowledge that this facility is PCI and HIPAA compliant, and my information is protected.

Patient/Guardian Signature:_____Date:_____

IV. OFFICE USE ONLY

Registration Date: _____ Processed by: _____

Form ID: REG-001