Patient Registration

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Tel: 440-268-9333

Patient Name_____[] Male [] Female Birth Date:_____Age:_____

Address:_____City:_____ State:____ Zip:_____

Alternate address for mailing (optional):_____

Home Phone:_____Work Phone:_____Social Security #____-____-_____

Employer/School_____Occupation_____

Marital Status: []Single []Married []Divorced []Widowed For minors only: child lives [] with both parents []mother []father

May we leave a message at your home with other residents? [] Yes []No On your answering machine/voice mail? []Yes [] No

E-mail address_____ Can we communicate with you via the Internet? [] Yes [] No

Other Physician:_____ May we provide him/her with update information [] Yes [] No

Who may we talk to about your medical concerns:_____

Is this contact only for emergency purposes only? [] Yes [] No, if not can we communicate on your behalf: [] Yes [] No

Relationship:_____ Phone # _____

Mother/Guardian:_____ Address (if different)_____

Date of Birth:_____Home Phone:_____Work Phone:_____

Father:_____ Address (if different)_____

Date of Birth:_____ Home Phone:_____ Work Phone:_____

Responsible party for insurance and bills: [] Patient [] Spouse [] Parents [] Mother [] Father []Other
Responsible party Date of birth:_____ Employer:_____ Phone #_____
Obtain copy of Driver's license [] Yes [] No

Primary Insurance Company:_____Name on contract:_____
Address:_____Group #_____ID #_____

PATIENT'S Relationship to cardholder: [] Self [] Spouse [] Dependent Card Copied: [] Yes [] No Co-payment; $_____

Secondary Insurance Company_____Name on Contract:_____
Address:_____Group #_____ ID #_____

PATIENT'S Relationship to cardholder: [] Self [] Spouse [] Dependent Card copied: [] Yes []No

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Identification of other physicians/health care entities involved with my medical care that I authorize ongoing release of information for continuity of care:

Referring Doctor:_____Phone:_____
Address:_____ Zip:_____
Type of physician/ health care provided:_____

Family Doctor:_____Phone:_____
Address:_____Zip:_____
Type of physician/ health care provided:_____

Information reviewed (initial):____/10____/11____/12____/13____/14____/15____/16____/17____/18____/19____/20____/21