

Family Health Care of Northwest Ohio Registration Form: Please complete all sections

PATIENT INFORMATION						
Last Name	First Name	MI	Soc. Security Number	Birth date	Sex M F	
Address			City	State	ZIP	
CONTACT INFORMATION						
Home Phone ()		Day/ Work Phone ()		Cell Phone ()		
Special instructions for telephone calls:						
E-Mail Address:						
Emergency Contact:						
Name: _____ Phone: _____ Relationship: _____						
Responsible Party (Required for patients under 18 years of age)						
Last Name	First Name	MI	Soc. Sec. Number	Birth Date	Relationship	
INSURANCE INFORMATION (Please present ALL insurance cards and a photo ID to the receptionist)						
Primary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay \$	Policy Number	Relationship
Secondary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay \$	Policy Number	Relationship
Tertiary Insurance	Policy Holder	Birth Date of	Effective	Co-Pay \$	Policy Number	Relationship
INFORMATION FOR STATISTICAL REPORTING ONLY:						
Please X to indicate your race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than one race						
Please X to indicate if you are Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please X to indicate your preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Creole <input type="checkbox"/> Other						
Please X Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other						
Please X Student Status: <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student						
Please X if you are a: <input type="checkbox"/> Veteran <input type="checkbox"/> Smoker						
Please X if you are homeless: <input type="checkbox"/> Doubling Up <input type="checkbox"/> Transitional <input type="checkbox"/> Shelter <input type="checkbox"/> Street						
I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.						
The preceding information is true to the best of my knowledge.						
_____			_____		_____	
Patient Name (Printed)			Signature of Patient/Responsible Party		Date	

