REGISTRATION FORM

PATIENT DEMOGRAPHICS

Patient name:_____ SSN:_____

Sex: ☐Male ☐Female Birthdate:_____

Permanent address:_____ Home phone:_____Primary? ☐

City:_____State:_____Zip:_____ Work phone:_____Primary? ☐

E-mail:_____ Cell phone:_____Primary? ☐

Language:_____ Interpreter needed? ☐Yes ☐No

Marital status: ☐Married ☐Single ☐Divorced ☐Widowed Ethnicity: ☐Hispanic ☐Not Hispanic

Race: ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Caucasian ☐Hispanic ☐Multi-Racial ☐Native Hawaiian ☐Other ☐Other Pacific Islander ☐Unknown

Research Patient? ☐Yes ☐No

PRIMARY CARE PROVIDER (PCP) INFORMATION – WHO IS YOUR PRIMARY CARE DOCTOR?

PCP:_____ PCP Phone:_____

Referring Provider:_____ Referring Provider Phone:_____

EMPLOYMENT

Employment status: ☐Full time ☐Part time ☐Retired ☐Not Employed Employer:_____

Address of Employer:_____ Employer Phone:_____

City:_____ State:_____Zip:_____ Employer Fax:_____

PATIENT CONTACTS

MEDICAL AND BILLING INFORMATION MAY BE RELEASED. SOME SITUATIONS MAY REQUIRE A WRITTEN AUTHORIZATION.

Contact 1:

Name:_____Home phone:_____Primary? ☐

Relationship:_____Work phone:_____Primary? ☐

Continued on Back

Legal guardian? ☐Yes ☐No Cell phone:_____Primary? ☐

PATIENT CONTACTS (CONTD)

Contact 2:

Name:_____Home phone:_____Primary? ☐

Relationship:_____Work phone:_____Primary? ☐

Legal guardian? ☐Yes ☐No Cell phone:_____Primary? ☐

GUARANTOR ACCOUNT QUESTIONNAIRE – BILLING RESPONSIBILITY QUESTIONS

Name of the person responsible for the final balance due on the account:_____

Relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other _____

SSN:_____ Sex: ☐Male ☐Female Birth Date:_____ Home phone:_____

Address:_____ Cell phone:_____

City:_____State:_____Zip:_____ Work phone:_____

Legal Guardian:_____

INSURANCE (PRIMARY COVERAGE)

Coverage (Insurance) name:_____

Who is the subscriber (policyholder) for the coverage?_____

SSN:_____DOB:_____Employer:_____

INSURANCE (SECONDARY COVERAGE)

Coverage (Insurance) name:_____

Who is the subscriber (policyholder) for the coverage?_____

SSN:_____DOB:_____Employer:_____

Signature:_____ Date:_____
Patient or Legal Representative

Printed Name and Authority of Legal Representative (if applicable):_____

OSU USE ONLY: THIS FORM IS TO BE SCANNED INTO PATIENT'S CHART