First Name: _____ Middle_____ Last_____ AKA_____ DOB_____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ Work # _____

Email address_____ SS # _____

**Preferred Method of Contact: ❑ Home ❑ Cell ❑ Work ❑ Email

**May we leave messages about appointments and results? (Check all that apply) ❑ No ❑ Yes

❑ Home ❑ Cell ❑ Work

Gender: ❑ M ❑ F Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

Race/Ethnicity: _____ Preferred Language: _____

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Minor Patients: Child lives with: _____ Contact #:_____

Mother/Guardian:_____ Contact #:_____

Father/Guardian: _____ Contact #: _____

Responsible Party, if different than above

Name: _____ Relationship to Patient: _____

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship: _____

ID/ SS#:_____ Group #: _____

Secondary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ Relationship: _____

ID/SS#: _____ Group #: _____

Is today's visit related to an accident? ❑ No ❑ Yes Date of Accident _____

OhioHealth

PATIENT IDENTIFICATION LABEL

3007214 (6/5/2013)

REGISTRATION FORM

If work related, please complete the following questions:

Employer: _____ Address: _____ Phone #: _____

Date of Injury: _____ Claim #: _____

Allowed Diagnosis: _____

MCO: _____ Phone#: _____

Case Manager: _____ Phone#: _____

Have you filed paperwork with your employer? ❑ No ❑ Yes

Do you have an attorney? ❑ No ❑ Yes

Name: _____ Phone#: _____

Many of our patients during their recovery may stay with family members, friends or at a rehabilitation or nursing facility. Please provide our office staff with information as to where you are currently staying so we are able to contact you.

I am staying with a: ❑ Relative ❑ Friend ❑ Rehabilitation Center ❑ Skilled Nursing Facility

Name of Relative/Friend/ Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have a Health Care Power of Attorney? ❑ No ❑ Yes

Name of POA: _____ Contact #: _____

(If yes, please provide a copy of the POA documents)

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Patient/Guardian Signature: _____ Date: _____ Time: _____