Ohio County HEALTHCARE

Patient Registration Form

Patient Information

Patient Information			
Last Name:	First Name: M.I.		Previous Name/Maiden Name:
Date Of Birth:	**Sex: (Circle One)** Male Female Transgender	**Marital Status: (Circle One)** Married , Single, Divorced, Widowed, Partner	Social Security #:
Mailing Address:			
Physical Address:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Do You Have: Advance Directive: Yes___ No___ Power Of Attorney: Yes___ No___ Living Will: Yes___ No___			
Family Physician:			
Employer Name:		Emergency Contact Name:	
Emergency Contact Phone #:		Relationship to Patient:	

Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian completing this form will be listed as the guarantor. We are not able to change this at each visit.		
Last Name:		First Name:
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:
Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No	
Race (Circle One) White, American Indian or Alaska Native, Asian, Hispanic, Black or African American, Native Hawaiian or Pacific Islander, Other , Decline		
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other		
Preferred Pharmacy Name & Location:		

Insurance Information

Medical Insurance	
Do you have more than one insurance carrier?	YES or NO
If Yes, did you provide copy of card front and back for ALL insurance carriers?	YES or NO
Is this a work related injury?	YES or NO
Is this an auto accident related injury?	YES or NO
If you have more than one insurance, one of which is Medicaid, Medicaid is always the last filed payer. All other insurances will have to be filed before Medicaid will pay.	

Signature of Responsible Party: ×______________________________________ **Date:**____________________

Printed Name of Responsible Party: ×______________________________________ **Date:**____________________

Clerk Signature: ×______________________________________ **Date:**____________________