640 Enterprise Drive Ste C Lewis Center, Ohio 43035 614.433.0132 www.ptpohio.com

PATIENT REGISTRATION FORM

Today's Date _____________

Patient Last Name First Name MI Date of Birth Sex SS#

Street Address City ST Zip Home Telephone

Mailing Address (if different from street address) Alternate Telephone

Legal / Financially Responsible Party

Last Name First Name MI Date of Birth Sex SS#

Street Address City ST Zip Home Telephone

Employer Name Address Work Telephone

Email

Insurance Information

Primary Insurance

Subscriber Name ____________________________
DOB _________ SS# ________________________
Ins. Company _______________________________
Claim Address ______________________________
____
ID / Contract# ______________________________
Group# ____________________________________
PCP _______________________________ (if listed)

Secondary Insurance

Subscriber Name ____________________________
DOB _________ SS# ________________________
Ins. Company _______________________________
Claim Address ______________________________
____
ID / Contract# ______________________________
Group# ____________________________________
PCP _______________________________ (if listed)

Please list the telephone number specified on your insurance card. ___________________________________

Emergency Contact

Name ________________________________ Telephone ________________ Relationship ___________________
Address ____
Do we have your authorization to contact this person concerning your medical services if the need arises?
____ yes ____ no ______ initial (patient or responsible party)

Consent and Release

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to _______________________ ____________________. I agree that I am responsible to pay for 1) for services not covered by my insurance company 2) co-payments and deductibles and 3) any expense associated with the collection of a debt owed to them by me (i.e. Attorney fee, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

x ______________________________________ ____________ ___________________________________
(Signature of Responsible Party) (Date) (Witness)