New Patient Registration

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

PATIENT INFORMATION

Today's Date

Family Doctor

Nickname

Last Name

First Name

Middle Name

Gender

☐ Male ☐ Female

Street Address

City

State

Zip

Birth Date

Age

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name?

☐ Yes ☐ No

If no, former/legal name

Home Phone

Cell Phone

Email

Social Security #

Employer Name

Employer Phone

How did you choose our clinic?

☐ Physician referral ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work

☐ Online search ☐ Other

Referring Provider Name

Referring Provider Phone

Referring Provider Address

INSURANCE INFORMATION — PLEASE HAVE YOUR INSURANCE CARD READY

Please give your insurance card to the receptionist at check-in.

Person Responsible for Bill

Birth Date

Address (if different)

Home Phone

Is this person a patient here?

☐ Yes ☐ No

Is the patient covered by insurance?

☐ Yes ☐ No

Primary Insurance

☐ Medicare ☐ Medicaid ☐ UHC ☐ Anthem ☐ Aetna ☐ Alliance ☐ BWC

☐ Healthspan ☐ Welfare ☐ Other

Subscriber's Name

Birth Date

SSN

Group #

Policy #

Co-payment

Patient's Relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (if applicable)

Subscriber's Name

Birth Date

Group #

Policy #

Patient's Relationship to Subscriber (secondary)

☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative

Relationship to Patient

Home Phone

Work Phone

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southwest Ohio Pain Institute or my insurance company to release any information required to process my claims.

Patient / Guardian Signature (type full name)

Date