Family Health Care of Northwest Ohio
Registration Form: Please complete ALL sections

PATIENT INFORMATION

Last Name	First Name	MI	Maiden Name	Date of Birth	Soc. Security Number

Sex at Birth: Male Female

Sexual Orientation: Straight Lesbian/Gay Bisexual (*please circle one*) Don't Know Something Else

Gender Identity: Male Female Other Transgender Male (Female to Male) (*please circle one*) Transgender Female (Male to Female) Choose not to report

Address	City	State	ZIP

CONTACT INFORMATION

Home Phone ( )	Day/ Work Phone ( )	Cell Phone ( ) ***For call/text***: FHCare is not responsible for usage or data rates if applicable.

Special instructions for telephone calls:

Preferred Contact Method:
(please circle one) Phone Mail e-mail

Would you like to access your medical records online through our secure patient portal? _____ YES_____ NO

E-Mail Address:

EMERGENCY CONTACT:

Name:_____ Phone:_____ Relationship: _____

HOUSEHOLD MEMBERS: Spouse: **Significant other:**

Children (first & last name):

HOUSEHOLD INCOME: (please circle one) $0-$10,000 $10,001-$20,000 $20,001-$30,000 $30,001-$40,000 $40,001-$50,000 $50,001-$60,000 $60,001-$70,000 $70,001-$80,000 $80,001-$90,000 $90,001-$100,000 $100,001+ Declined

PLACE OF EMPLOYMENT:
(Include City and State)

Preferred Pharmacy:

RESPONSIBLE PARTY (Required for patients under 18 years of age)

Last Name	First Name	MI	Soc. Sec. Number	Birth Date	Relationship

INSURANCE INFORMATION (Please present ALL insurance cards and a photo ID to the receptionist)

Primary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay $	Policy # Group #	Relationship
Secondary Insurance	Policy Holder	Date of Birth	Effective	Co-Pay $	Policy # Group#	Relationship

INFORMATION FOR STATISTICAL REPORTING ONLY:

Please **X** to indicate your race: __White __Black/African American __American Indian __Asian __Native Hawaiian __Other Pacific Islander __More than one race

Please **X** to indicate if you are Hispanic: ____Yes ____No

Please **X** to indicate if you are a Migrant worker: ____Yes ____No

Please **X** to indicate if you are a Seasonal worker: ____Yes ____No

Please **X** to indicate your preferred language: ____English ____Spanish ___French ____ Creole ____Other

Please **X** Marital Status: **____**Single ____Married ____Widowed _____Legally Separated ___Divorced

Please **X** Student Status: ____Full-Time Student ____Part-Time Student

Please **X** if you are a: **____Veteran ____Smoker**

Please **X** if you are homeless: ___Doubling Up ___Transitional ___Shelter ___Street

Please list any spiritual/cultural beliefs that may affect medical care: _____

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.

I have received a copy of the Notice of Privacy Practices

The preceding information is true to the best of my knowledge.

_____ _____ _____

Patient Name (Printed) **Signature of Patient/Responsible Party** **Date**