REGIONAL PHYSICIANS
Patient Information Sheet

Patient's Full Legal Name: ____

(First Middle Last)

Social Security Number: ______________________ **Sex: Male ____ Female ____ Date of Birth:** ____________ **Age:** _____

Marital Status: (CIRCLE ONE) Single Married Widowed Divorced Separated

<u>We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported</u>.
(Please Check ONE in <u>EACH CATEGORY</u> that applies)

RACE		ETHNICITY	PREFERRED LANGUAGE	
☐ White	☐ More Than One	☐ Hispanic or Latino	☐ English	☐ Hindi
☐ Black or African American	☐ Native Hawaiian	☐ Not Hispanic or Latino	☐ Spanish	☐ Vietnamese
☐ Asian	☐ Other Pacific Islander	☐ Undefined	☐ Urdu	
☐ American Indian or Alaskan Native	☐ Undefined	☐ Refused to Report or Unreported	☐ Refused to Report or Unreported	
☐ Refused to Report or Unreported			☐ Other ______________________	

PATIENT ADDRESS INFORMATION

Address: ____
Street City State Zip Code

<u>EMAIL ADDRESS</u>: ____

Home Phone: (   ) ______________________ **Work Phone: (   )**__________________ **ext.** __________

Cell Phone: (   ) ______________________

Primary Care Physician ______________________ **Referring Provider Name:** ______________________

HOW DID YOU HEAR ABOUT US? (Please Check the ONE that applies)

☐Family/Friend	☐ Online Yellow Pages	☐ Employer Website	☐ Internet Search	☐ Billboard
☐Hospital	☐ Newspaper	☐ Mailer	☐ Radio	☐ Doctor
☐Seminar-Special Event	☐ Sports Team Support	☐ TV	☐ Worker's Comp	☐ Other: ________________
☐Existing Patient	☐ Self Referral			☐ Other ________________

<u>IS THIS A WORKERS COMPENSATION CLAIM? (CIRCLE ONE) Yes No</u>

IF YES, PATIENT SHOULD ALSO FILL OUT WORK COMP INFO SHEET

<u>DID YOUR EMPLOYER SEND YOU HERE FOR A SCREENING, PHYSICAL or VACCINATION? (CIRCLE ONE) Yes No</u>

IF YES, PATIENT SHOULD ALSO FILL OUT OHC INFO SHEET

PLEASE HAVE YOUR INSURANCE CARD(S) AND PHOTO ID READY TO BE COPIED

GROUP INSURANCE INFORMATION

Primary Insurance:____ **Member ID:**_____________________________________

Policyholder Name: ____ **Policyholder Date of Birth:**_________________________

Group #: ____________________**Patient's Relation to Policyholder: (CIRCLE ONE) Self Wife Husband Child Parent Other**

Secondary Insurance:____ **Member ID:**_____________________________________

Policyholder Name: ____**Policyholder Date of Birth:** _________________________

Group #: ______________________**Patient's Relation to Subscriber: (CIRCLE ONE) Self Wife Husband Child Parent Other**

EMERGENCY CONTACT INFORMATION

Emergency Contact: ____**Relationship:** _____________________________________

Home Phone: ( )____________________ **Work:** ( )________________________ **Cell:** ( ) _____________________________

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN/GUARANTOR SECTION BELOW

Parent/Guardian/Guarantor Name: ____

Address:____

(if different from above) Street City State Zip Code

Home Phone: ( ) ______________________ **Work:** ( )_________________________ **Cell:** ( ) _________________________

Social Security #: __________________________________ **Date of Birth:** ______________ **Sex: M** _____ **F** _____

Marital Status: (CIRCLE ONE) Single Married Widowed Divorced Separated

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment: I** consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information: I** authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits: I** authorize payment of medical benefits to Regional Physicians, LLC.

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Regional Physicians for charges not covered by insurance.

____ __________________________________

Signature of Patient or Legal Representative Date

2/2011