805 Columbia Rd. Suite 105, Westlake, Ohio 44145 Phone: 440-250-0696 Fax: 440-250-1857

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Marital status:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ☐ M ☐ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Race:	Ethnicity:
Language:	

Email Address:
Phone no.

Pharmacy:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

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Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

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 Regina Hill MD, Inc. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date