



NORTHERN OHIO MEDICAL SPECIALISTS  
HEALTHCARE

Date: \_\_\_\_\_

Patient Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: M S W D Do you have insurance through work?  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best time to reach you by phone: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Do you have insurance through work?  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If you are covered under your parents insurance, OR a minor, you **MUST** complete the following:

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Are you covered under your mother's insurance?  Yes  No Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Check if below is same as above

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Are you covered under your father's insurance?  Yes  No Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Check if below is same as above

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

In case of emergency who should we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

---

### INSURANCE INFORMATION

We apologize for any inconvenience, but we **MUST** have a copy of your medical insurance cards before you can see the physician.

Primary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Check if below policy holder information is same as front

Date of Birth: \_\_\_\_\_ Sex:  M  F SS#: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

---

Secondary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Check if below policy holder information is same as front

Date of Birth: \_\_\_\_\_ Sex:  M  F SS#: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

---

Is this a work related injury?  Yes  No

MCO: \_\_\_\_\_ Claim: \_\_\_\_\_

1st Report of Injury?  Yes  No Employer at time of injury: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_ Employer's Fax #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Initials of person completing form if other than patient: \_\_\_\_\_