SCANNED IN CHART:
☐ GUARDIANSHIP
☐ CUSTODY
☐ ADVANCED DIRECTIVE (LIVING WILL, DURABLE POWER OF ATTORNEY FOR HEALTHCARE)

PATIENT REGISTRATION FORM

Information for the Patient Being Seen Today

LAST NAME _____ FIRST NAME _____ M.I. _____ GENDER: ☐ Male ☐ Female

ADDRESS_____ CITY_____ ST_____ ZIP _____

PRIMARY PHONE_____ WORK PHONE_____ CELL PHONE_____

EMAIL ADDRESS_____ DATE OF BIRTH_____

SOCIAL SECURITY #_____ MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ OTHER

PREFERRED PHARMACY _____

ETHNICITY: ☐ NON- HISPANIC OR LATINO; ☐ HISPANIC OR LATINO

RACE: ☐ HISPANIC OR LATINO; ☐ WHITE; ☐ BLACK OR AFRICAN AMERICAN; ☐ NATIVE AMERICAN OR OTHER PACIFIC ISLANDER
☐ ASIAN; ☐ AMERICAN INDIAN OR ALASKA NATIVE; ☐ TWO OR MORE RACES

PREFERRED LANGUAGE:: ☐ ENGLISH ☐ OTHER: _____

Patient care decisions are made without regard to race, religion, age, sex, color, national origin, disability and in full compliance with all Federal and State laws.

FOR ALL PEDIATRIC PATIENTS

MOTHER

LAST NAME_____ FIRST NAME_____

ADDRESS WITH CITY/STATE/ZIP_____

_____

SS#_____ DATE OF BIRTH_____

MARITAL STATUS_____ PHONE_____

EMPLOYER NAME AND_____

ADDRESS_____

HOW LONG EMPLOYED_____

WORK PHONE_____

INSURANCE _____

PRIMARY _____ SECONDARY____

FATHER

LAST NAME_____ FIRST NAME_____

ADDRESS WITH CITY/STATE/ZIP_____

_____

SS#_____ DATE OF BIRTH_____

MARITAL STATUS_____ PHONE_____

EMPLOYER NAME AND _____

ADDRESS_____

HOW LONG EMPLOYED_____

WORK PHONE_____

INSURANCE _____

PRIMARY _____ SECONDARY____

With whom does the patient reside? (Check all that apply)
☐ *Mother* ☐ *Father*
☐ *Joint custody*
☐ *Other (identify:_____)*

Who has legal custody of the child? (Check all that apply)
☐ *Mother* ☐ *Father*
☐ *Joint custody*
☐ *Other (identify:_____)*

Please note that OMH will assume that a biological or adoptive mother and father have full legal ability to obtain information about their child and to seek medical treatment about their child unless a court order is presented and on file with OMH.

(Complete both sides)

PATIENT REGISTRATION FORM

Information for the Patient Being Seen Today

FOR ALL ADULT PATIENTS

EMPLOYER'S NAME_____ ADDRESS_____

CITY_____ ST_____ ZIP_____

SPOUSE'S NAME_____ SPOUSE'S WORK PHONE_____

SPOUSE'S DATE OF BIRTH_____

PRIMARY CARE DR / REFERRED BY_____ ADDRESS_____ PHONE_____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

PERSON RESPONSIBLE FOR PAYMENT

☐ **PATIENT**
☐ **MOTHER/GUARDIAN** ☐ **FATHER/GUARDIAN**

LAST NAME _____FIRST NAME _____ M.I. _____ GENDER: ☐ Male ☐ Female

DATE OF BIRTH_____

ADDRESS_____CITY_____ ST_____ ZIP _____

SOCIAL SECURITY #_____ RELATIONSHIP TO PATIENT_____

EMPLOYER'S NAME_____ ADDRESS_____

CITY_____ ST_____ ZIP_____

OCCUPATION_____HOW LONG EMPLOYED_____WORK PHONE_____

NEAREST RELATIVE OR EMERGENCY CONTACT PERSON: (Other than Spouse)

LAST NAME_____ FIRST NAME_____M.I._____

DATE OF BIRTH_____ RELATIONSHIP_____

ADDRESS_____CITY_____ ST_____ ZIP _____

EMPLOYER_____PRIMARY PHONE_____WORK PHONE_____

Agreement for Payment/Permit Payment of Medical Benefits

I hereby authorize OMH Medical Group staff and its representatives to render routine health care to myself or my child. I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examinations, administration of medications, diagnostics such as laboratory or radiology services, and/or minor procedures. I understand that I may discontinue services at any time.

In consideration of the services rendered, I hereby expressly agree to pay in full, any and all charges for provider services rendered at Otsego Memorial Hospital Medical Group clinics and materials furnished to or for the patient by Otsego Memorial Hospital providers. I hereby assign payment directly to Otsego Memorial Hospital of authorized benefits to be made in my behalf, not to exceed the balance due of the provider's regular charges. I understand that I am financially responsible to the hospital for charges not covered by this authorization under the provisions of the Federal Truth in Lending Law 7196.

SIGNATURE_____DATE_____