838 E. Wooster St. Bowling Green, OH 43402 Phone: 419.372.2271 Fax: 419.354.3222

**PATIENT INFORMATION**

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name**: \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

(Last) (First) (Middle)

Patient Birthdate: \_\_ \_/\_\_ \_/\_\_\_ \_ SSN: \_\_\_ \_/\_\_ \_/\_\_ \_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Sex: Male Female Gender Identity: Male Female Other: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_ \_ \_\_\_ \_\_\_

**Billing Address or PO Box**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_­­­­­\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_ State: \_ \_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please place an X by your primary phone number***

□ Home Phone: (\_\_ \_) \_\_\_ \_\_-\_\_\_\_ \_\_ □ Work Phone:(\_ \_ \_) \_\_ \_\_\_-\_\_\_\_ \_ □ Cell Phone: (\_ \_\_) \_\_\_\_- \_

Appointment Reminders**:** Text Messages Phone Call Both

**Marital Status:** Single Married Divorced Widowed

**BGSU Student:** **€** Full Time **€** Part Time **€** NA

**Race:** Asian Black or African American Indian Multi-Racial Pacific Islander White Other

**Ethnicity:** Not Hispanic Hispanic

**Primary Language:** English Spanish Arabic French Other: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_ Phone:(\_\_ \_) \_ \_\_-\_\_\_ \_

**€** Full Time **€** Part Time **€** Retired

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

**How did you hear about the Falcon Health Center**?

**Pharmacy** Falcon Health Center Pharmacy Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your Family Doctor:** (PCP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_ \_

**Emergency Contact**

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

Primary Phone: (\_\_\_\_\_) \_\_ \_\_-\_ \_\_\_\_ Alternate Phone: (\_\_\_\_\_) \_\_ \_\_-\_ \_\_\_\_

Please Complete the Back of this Form

Additional Information required (**only if the patient is a minor**) or **STUDENT**

|  |  |
| --- | --- |
| **Mother**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_ \_/\_\_ \_/\_\_\_ \_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ State:\_\_\_\_  Zip:\_\_\_\_\_\_\_\_\_  Home Phone:\_\_\_\_ \_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_ \_\_\_\_\_ | **Father**  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_ \_/\_\_ \_/\_\_\_ \_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ State:\_ \_  Zip:\_\_\_\_\_\_\_\_  Home Phone:\_\_\_\_ \_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_ \_\_\_\_\_\_ |

Minor Resides with, Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Relationship\_\_\_ \_\_\_\_\_

Revised 11/08/2019

**\*\*Please present all insurance cards to the Receptionist\*\***

*Any photos of insurance cards, please e-mail to* [FHCQA@woodcountyhospital.org](mailto:FHCQA@woodcountyhospital.org)

**Primary Insurance**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Visit Co-Payment: $ \_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth: \_ \_\_/\_ \_\_/\_\_ \_

Relationship to Patient: \_\_\_ \_\_\_\_\_\_­\_\_\_\_ SSN of Policy Holder: \_ \_\_\_/\_ \_\_/\_\_ \_\_

Effective: \_\_\_ \_/\_\_ \_\_/\_\_ \_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

**Secondary Insurance** (if applicable)

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Office Visit Co-Payment:$ \_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth:\_ \_\_/\_ \_\_/\_\_ \_

Relationship to Patient: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_ SSN of Policy Holder: \_ \_\_\_/\_ \_\_/\_\_ \_

Effective: \_\_\_ \_/\_\_ \_\_/\_\_ \_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_