

Falcon Health Center

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

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

****Please present all insurance cards to the Receptionist****
Any photos of insurance cards, please e-mail to 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: _____

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

<u>Mother</u>	<u>Father</u>
Name: _____	Name: _____
Date of Birth: ____/____/____	Date of Birth: ____/____/____
Address: _____	Address: _____
City: _____ State: _____	City: _____ State: _____
Zip: _____	Zip: _____
Home Phone: _____ Cell: _____	Home Phone: _____ Cell: _____

Minor Resides with, Name: _____ Relationship _____

Would you like to enroll in the patient portal? Yes No

Email to be used: _____

Please see a receptionist for your token.