Van Wert Health

Patient Information

Patient Name (Last, First, MI)

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed

Is this your legal name?
☐ Yes ☐ No

Maiden Name/Previous Name

Birth Date

Age

Sex
☐ M ☐ F

Street Address/PO Box

Social Security Number

Home Phone Number

City

State

Zip Code

Cell Phone Number

Employer

Email Address

Employment Status
☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Part-Time Student ☐ Full-Time Student

Race
☐ White ☐ Hispanic ☐ African-American
☐ Multi-Race ☐ Other:_____

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Primary Language
☐ English ☐ Spanish
☐ Other:_____

Office/Practitioner you wish to see

Have you been seen in our office before?
☐ Yes If so, what year? _____ ☐ No

Insurance Information (please give your insurance card to the receptionist)

Person Responsible for Bill

Birth Date

Address (if different)

Home Phone Number

Employer

Employer Phone Number

Is This Person a Patient Here?
☐ Yes ☐ No

Primary Insurance Name/ID or Policy Number

Subrscriber's Name

Subrscriber's Social Security No.

Subscriber's DOB

Subrscriber's Address

Subrscriber's Phone Number

Patient's Relationship to Subrscriber

Secondary Insurance Name (if applicable)

Subrscriber's Name

Subrscriber's Social Security Number

Subrscriber's Address

Subrscriber's Phone Number

Patient's Relationship to Subrscriber

In Case of Emergency

Name of Friend or Relative

Relationship to Patient

Home Phone Number

Work Phone Number

Other Information

Current Family Physician

How did you hear about us?

New Patients: Reason for wanting to leave current physician:

Form revised August 2021