Today's Date_____

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Phone: (614)457-5588 Facsimile: (614) 457-6736

Registration Form

Referred by: _____

Name: (Last)_____ (First)_____ (MI) ____

Address:_____

City:_____ State:_____ Zip:_____

Age:____ Date of Birth:_____ Social Security Number:_____-____-_____

Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Partnered [ ] Widowed [ ]

Telephone number where we may contact you: Home:_____

Work:_____ Other:_____

If you are Private Pay - Please stop here.

****

Payment is due upon receipt of service unless other arrangements have been made in advance.

If you would like services rendered submitted to your insurance company or outside agency please complete the area below. You will also be asked to complete and sign a Release of Information provided to you with this form.

- **I will need to copy your health insurance card to keep with my records.**

INSURED:
Name: (Last)_____ (First)_____ (MI)____

Address (if other than above)_____

City_____ State_____ Zip_____

Age: _____ Date of Birth: _____ Social Security Number: _____-___-_____

Employer: _____ Telephone: _____

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Please give me the names and addresses of other treating physicians:

_____

_____

_____

_____

_____

_____

Would you be kind enough to give me a brief description of the concerns you would like to discuss with me today?