MT AUBURN URGENT CARE
2230 Auburn Avenue
Cincinnati, OH 45219
PH: 513-621-2200

REGISTRATION FORM

PATIENT NAME
____
(last) (first) (middle)

BIRTH DATE__________________SEX: M / F SS#________________
EMAIL______________________________

AD-
DRESS____ZIP________
__
(street) (city) (state)

HOME PH ________________________WORK PH__________________________CELL
PH_____________________

EMPLOYER____OCCUPA-
TION____________________________

WORK AD-
DRESS____ZIP____________
(street) (city) (state)

SPOUSE/PARENT/NEXT OF KIN/LEGAL
GUARDIAN____
(last/first/middle)

SOCIAL SECURITY #____CONTACT
PHONE________________________

HOW DID YOU HEAR ABOUT US? **SIGNS/BILLBOARD/GOOGLE/INSURANCE/ FACEBOOK/ FRIENDS-REL-ATIVES/**
"SIGN GUY"/ RADIO AD / OTH-
ER____

Would you like us to be your primary care provider?
____

How do you prefer to be contacted: ______phone ______email _____other

PRIMARY INSURANCE________________________POLICY/
ID#____________________GROUP#_________________
INSURED NAME____BIRTH
DATE_________________________________
(last/first/middle)
RELATIONSHIP TO INSURED__________________________SOCIAL SECURITY # OF IN-
SURED______________________

(The federal government requires this information for electronic medical records. You have the right to choose "declined")
RACE: white/caucasion, black/African American, Asian, Indian, native American, hispanic, other, declined (please circle)
-
PRIMARY LANGUAGE____MARITAL STA-
TUS____

SIGNED____-
DATE_____________________
(patient/guardian/parent/next of kin)