****ALL INFORMATION MUST BE COMPLETED****

MID-OHIO PEDIATRICS & ADOLESCENTS, INC.
465 N. CLEVELAND AVE. SUITE 200
WESTERVILLE, OH 43082

ACCT# _____

For 18 and older

PATIENT INFORMATION

Legal Last Name _____ Legal First Name _____ MI _____ Nickname _____

Male____ Female____

Date of Birth _____ Transgender____ Phone Number _____

Residential Address _____ City _____ State _____ Zip _____

PRIMARY EMERGENCY CONTACT

Last Name _____ First Name _____ Male____ Female____ Transgender____

Primary Contact Number _____ Relationship To Patient _____

_____ I **AUTHORIZE** Mid-Ohio Pediatrics and Adolescnts to release Protected Health Information to this individual.

_____ I **DO NOT** authorize Mid-Ohio Pediatrics and Adolescnts to release Protected Health Information to this individual.

SECONDARY EMERGENCY CONTACT

Last Name _____ First Name _____ Male____ Female____ Transgender____

Primary Contact Number _____ Relationship to Patient _____

_____ I **AUTHORIZE** Mid-Ohio Pediatrics and Adolescnts to release Protected Health Information to this individual.

_____ I **DO NOT** authorize Mid-Ohio Pediatrics and Adolescnts to release Protected Health Information to this individual.

PREFERRED PHARMACY

Pharmacy Name _____ Address _____ Phone Number _____

INSURANCE (Please present all current insurance cards to the Front Desk)

****Failure to disclose all current insurance coverage including State Funded insurance may result in dismissal from our practice****

Primary Insurance Company _____ Policy Holders Full Name _____ Date Of Birth _____

ID/Subscriber Number _____ Group Number _____ Policy Effective Date _____

Is the Insurance through; (circle one)

Employer MarketPlace State Funded Individual Policy Copay Amount _____ Relationship To Patient _____

Secondary Insurance Company _____ Policy Holders Full Name _____ Date Of Birth _____

ID/Subscriber Number _____ Group Number _____ Policy Effective Date _____

Is the Insurance through; (circle one)

Employer MarketPlace State Funded Individual Policy Copay Amount _____ Relationship To Patient _____

Patient Signature _____ Date _____