Morrow County Health Department
Registration and Consent Form

Please Print

Patient's Legal Last Name:	First:	Middle:	Marital status : ❑ Single ❑ Married ❑ Widowed ❑ Divorced

(Former Name):	Race:	Ethnicity:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	P.O Box:	City:

State:	ZIP Code:	Preferred phone number: ( ) -	Type: ❑ Home ❑ Cell ❑ Work
Name of emergency contact :	Relationship to patient:	Primary phone no.:	Secondary phone no.:

If the patient does not have insurance, and you would like to determine if you are eligible for discounted services, please complete the box below.

I state that there are _____ people living in my household and the combined household income is $ _____ per ❑ week ❑ every 2 weeks ❑ month ❑ year (check one)

PLEASE FILL OUT ALL INSURANCE INFORMATION.

Primary Insurance (Name of Company):			Is this **patient** covered by insurance? ❑ Yes ❑ No If yes, insured's relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Name of primary insured:	Primary insured's birthdate:		Primary insured's address (if different than patient's):
Primary insured's phone number:	Co-pay:	Group number:	Member ID number:

Secondary Insurance (Name of Company):			Is this **patient** covered by insurance? ❑ Yes ❑ No If yes, insured's relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Name of secondary insured:	Secondary insured's birthdate:		Secondary insured's address (if different than patient's):
Secondary insured's phone number:	Co-pay:	Group number:	Member ID number:

I have read the Morrow County Health Department's Patient Financial Policy and agree to the terms of this policy. I understand that I may request a copy to take home if desired. I also understand that it is my responsibility to verify with my insurance company coverage of all services requested, and that I will be responsible for any balance not paid or covered by my insurance company. I agree to pay any amount remaining due to the Morrow County Health Department for the service(s) provided.

I request and authorize the Morrow County Health Department and its personnel to deliver medical care. I authorize the Morrow County Health Department to release any information that is required by my insurance company in order to process my claims. I understand that any vaccines received will be entered into the Statewide Immunization Information System for my convenience. The above information is true and correct to the best of my knowledge and I agree to provide updated information if there are any changes.

Patient or Legal Guardian Name (please print) _____

Relationship to Patient (if patient is a minor)_____ **Patient/Guardian Birthdate**_____

Patient or Legal Guardian Signature_____