

Ottawa Regional Medical Center, Inc.

PATIENT INFORMATION				
Patient Last Name	M.I.	Legal First Name	Home Phone	
Street Address			Cell Phone	
City		State	Zip	Work Phone
Sex	Social Security Number		Date of Birth	Marital Status
Employer		Employer Address		
INSURANCE INFORMATION				
Primary Insurance Carrier		Secondary Insurance Carrier		
Subscriber ID/Policy #	Group #	Subscriber ID/Policy #	Group #	
Complete the following if Patient is not the Subscriber		Complete the following if Patient is not the Subscriber		
Subscriber Name		Subscriber Name		
Date of Birth	Social Security Number		Date of Birth	Social Security Number
Relationship to Patient		Relationship to Patient		
PARENT INFORMATION (If patient is under 18 or insurance is in parent's name, please complete this section)				
Name		Date of Birth		
Employer		Employer Phone		
EMERGENCY CONTACT				
Name	Relationship	Phone	Address	
AUTHORIZATION TO RELEASE MEDICAL INFORMATION				
<p>I understand that payment is required at the time of service and should my claim be filed to my insurance company, any unpaid balance is my responsibility. When Necessary, I further authorize release of medical records to my insurance company. I understand that the Ottawa Regional Medical Center physicians may recommend and perform services not covered by my insurance carrier. In consideration of services rendered and materials furnished to me or my child I agree to pay and/or authorize payment of medical benefits to the Ottawa Regional Medical Center, Inc.</p> <p style="text-align: center;">I have read and agree to the above statements</p> <p>Signed: _____ Date _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Patient / Parent / Guardian Date </div> </p> <p style="text-align: center;">We need your help!</p> <p>In order to provide excellent service to you and your family, we depend upon <u>you</u> for current and accurate information. Please inform us immediately if your insurance or contact information changes.</p>				
NPP Acknowledgement Date:		Authorization to Notify Exp. Date:		
HFS PCP:		Physician:		

THANK YOU!!!