SUMMIT COUNTY PUBLIC HEALTH
REGISTRATION FORM

Summit County Public Health

1867 West Market Street ♦ Akron, Ohio 44313-6901

Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558

Date: ____________________________ **Patient #:** ___________

Reason for Visit:

☐Received a post card ☐Received a phone call ☐New patient ☐Return visit

Patient Information:

Last Name:_________________________________ First Name: _______________________________Middle Initial: ______

Address: ___________________________________ City: _______________________ State: __________ Zip: ________

Home Phone: _________________ Cell Phone: ________________ E-Mail Address: _______________________________

Date of Birth: ____/____/______ Age:_____ Male ☐ Female ☐ Social Security Number:____________________

Single ☐Married ☐ Divorced ☐Separated ☐Widowed ☐Minor ☐

Mark all that apply: African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐

American Indian-Alaskan Native ☐ Other__________________ ☐

In Case of Emergency, who should be notified?____

Phone: ( ) ______________________________________ Relationship: ____________________________________

Doctor's Name: ____ Phone number: __________________________

Specialty Doctor's Name: ____________________________________ Phone number: __________________________

Dentist's Name: ____ Phone number: __________________________

Insurance information

☐I have insurance coverage

☐I have no insurance coverage

Does your insurance cover immunizations? ☐Yes ☐No

Healthy Start application date applied: ____/____/______

Primary Insurance Coverage

Name and Address of insurance company ____ Effective date____/____/______

Name of person on card _______________________________________ SS #________________ Birth date____/____/_____

ID # on card ______________________________________ Group # on card _______________________________________

Secondary Insurance Coverage

Name and Address of insurance company ____ Effective date____/____/______

Name of person on card _______________________________________ SS #_________________ Birth date____/____/____

ID # on card ______________________________________ Group # on card _______________________________________

Employment/Income Information

Source of Income/Employer #1________________________ Address __________________________ Phone____________

Source of Income/Employer #2________________________ Address __________________________ Phone____________

Income: Weekly _____________ Bi-weekly ________________ Monthly _______________ Yearly__________________

Documentation provided (copy and attach) ____

☐ Please check this box if you would like information about other resources or programs offered in our community. (If you have specific needs for your family, you may list them below and a nurse will be happy to help you when you are seen)

Thank you for visiting our clinic!

Date ________________ **Number in household** ________________**Sliding Fee Scale Percentage**__________

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Date ________________ **Number in household** ________________**Sliding Fee Scale Percentage**__________

Insurance/Payment Progress Notes