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 STATUS_____

SIGNED_____-
DATE_____
(patient/guardian/parent/next of kin)