Patient Registration Form

Primary Care Physicians of Stow, LLC
1355B Corporate Drive
Hudson, Ohio 44236

Patient Information

Patient Name: _____
(Last) (First) (MI)

Home Phone: (___)_____ Cell Phone: (___)_____Work:(____)_____

Employer: _____
(Name) (Address)

Marital Status (check one) ___Married ____Single _____Divorced ____Widowed

Employment Status (check one) ____Full -time ____Part-time _____Retired _____N/A

Student Status (check one) _____Full- time _____Part-time

Guarantor Information

(The person who is responsible for the insurance)

Guarantor's Name_____ DOB_____

Guarantor's Address_____

Relationship to Patient_____

Home Phone: (___)_____ Work Phone: (___)_____

Guarantor's Employer:_____

Insurance Information

Primary Insurance_____ ID#_____ Group#_____

Subscriber's Name_____ Subscriber's DOB:_____ Relationship_____

Secondary Insurance_____ ID#_____ Group#_____

Subscriber's Name _____ Subscriber's DOB _____ Relationship _____

Emergency Contact

Person to call in case of an emergency:
Name: _____
Phone:_____
Relationship:_____

Minor Information

If patient is a minor, legal guardian's name: _____
Legal guardian's address:_____
Legal guardian's home phone (___)_____ Work phone: (___)_____

Guardianship Authorization:
I give _____ permission to bring my child _____
To Dr Pennie Marchetti for medical treatment.

_____
Parent/Legal Guardian Signature

Absence Authorization:
I give Dr Pennie Marchetti my permission to evaluate and treat my child _____
In my absence.

_____
Parent/Legal Guardian Signature

Miscellaneous Information

You have my permission to discuss my medical record information and account information with:

_____

I authorize my insurance benefits to be paid directly to Primary Care Physicians of Stow realizing I am responsible for payment for my medical services and I authorize the release of pertinent medical information to insurance carriers. I authorize Dr Pennie Marchetti, as my primary care physician, to release pertinent medical information to consulting physicians.

_____
Patient/Parent/Legal Guardian **DATE**