North Coast Health
A faith-based charitable clinic
216.228.7878 | northcoasthealth.org
16110 Detroit Avenue | Lakewood, OH 44107

Patient Registration

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____

City, State: _____ Zip: _____

Date of Birth: _____ Phone #: _____

Social Security #: _____ E-mail: _____

Gender
❑ Male
❑ Female

Contact Preference
❑ Phone
❑ E-mail

Demographics
Total Members in your Household: _____
Annual Family Income: _____

Do you speak English?
❑ Yes
❑ No → What is your preferred language?
_____

Insurance Status
❑ Uninsured
❑ Medicaid
❑ Veteran
❑ Medicare → Do you have Part D? ❑ Yes ❑ No
❑ Other (please specify): _____

Employment
❑ Full-Time
❑ Temporary
❑ Part-Time
❑ Unemployed
❑ Self-employed
❑ Contract

Marital Status
❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

Race
❑ White
❑ Black
❑ Native American
❑ Asian
❑ Pacific

Ethnicity
❑ Hispanic
❑ Non-Hispanic

US Citizen?
❑ Yes
❑ No

Insurance Information – *Present your insurance card and photo ID at Registration*

Primary Insurance
Insurance Name: _____
Policy #: _____
Group#: _____
Insured's name: _____
Insured's DOB: _____
Relationship to patient: _____

Secondary Insurance
Insurance Name: _____
Policy #: _____
Group#: _____
Insured's name: _____
Insured's DOB: _____
Relationship to patient: _____

ASSIGNMENT OF BENEFITS
I hereby assign or transfer payment benefits made to me and my behalf to North Coast Health for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION
I hereby authorize North Coast Health to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare or Medicaid patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

Emergency Contact

Name: _____

Phone #: _____

If someone helped you with this application, and you want them to answer questions for you, please give us their name and phone number.

Helper's name: _____

Phone #: _____

SIGNATURE OF APPLICANT/PATIENT OR LEGAL GUARDIAN
By my signing below, I certify that everything I have stated on this application and on any attachments is true.

X _____ Date: _____