



# 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

<b>Primary Insurance</b>	Insurance Name: _____	<b>Secondary Insurance</b>	Insurance Name: _____
	Policy #: _____		Policy #: _____
	Group#: _____		Group#: _____
	Insured's name: _____		Insured's name: _____
	Insured's DOB: _____		Insured's DOB: _____
	Relationship to patient: _____		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: \_\_\_\_\_