

P# _____

Dr# _____

**CENTRAL OHIO PRIMARY CARE
FAMILY PRACTICE CENTER OF WESTERVILLE**

190-A South State Street • Westerville, Ohio 43081-2200 • www.fpcw.net • (614) 882-2349 • Fax 614-882-9005
CAROL C. HOSTETTER, D.O. • ANN H. CALLAND, D.O. • ANDREW P. EILERMAN, D.O.

PATIENT REGISTRATION FORM - ADULT

PATIENT'S **FULL LEGAL** NAME _____ NICK NAME _____
PLEASE PRINT IF ANY

ADDRESS _____
CITY _____ ST _____ ZIP _____
PATIENT'S DATE OF BIRTH ____/____/____ EMAIL ADDRESS _____
MARITAL STATUS: __S __M __D __W __PARTNER RACE __White __Black __Hispanic __Asian __Other _____

INFORMATION ON FAMILY MEMBER CARRYING THE INSURANCE
INSURED'S **FULL LEGAL** NAME _____ RELATIONSHIP TO PATIENT _____
ADDRESS IF DIFFERENT FROM ABOVE _____
RESPONSIBLE PARTY DATE OF BIRTH ____/____/____ RESPONSIBLE PARTY SS# ____/____/____
RESPONSIBLE PARTY HOME PHONE (____) _____
RESPONSIBLE PARTY PLACE OF EMPLOYMENT _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTCARE OPERATIONS
I consent to the use or disclosure of my protected health information by Central Ohio Primay Care — Family Practice Center of Westerville, for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care and to conduct health care operations. I understand that diagnosis and treatment of me by Family Practice Center of Westerville, may be conditioned upon my consent as evidenced by my signature on this document.
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Family Praclice Center of Westerville is not required to agree to the restrictions that I may request. However, if Family Practice Center of Westerville agrees to a restriction that I request, the restriction is binding on Central Ohio Primary Care — Family Practice Center of Westerville.
I have the right to revoke this consent, in writing, at any time, except to the extent that Central Ohio Primary Care — Family Practice Center of Westerville has taken action in reliance on this consent.
My "protected health information" means health information, including any demographic information collected from me or received by my physician, another health care provider, my employer or health care clearinghouse. This protected health information related to my past present and future physical or mental heath or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
I understand that I have a right to have provided to me and review Central Ohio Primary Care — Family Practice Center of Westerville, Notice of Privacy Practices before signing this document. The Notice of Privacy Practices is also posted for review in the reception area. This notice describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the practice of health care operations of the practice.
Central Ohio Primary Care — Family Practice Center of Westerville reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by call the office and requesting that a revised copy be sent to me or asking for one at the time of my next appointment.

Signature of patient or personal representative Description of personal representative authority: Self, Parent, POA Date

In Mysis _____

P# _____

Dr# _____

**REQUEST FOR CONFIDENTIAL INFORMATION
PLEASE COMPLETE EVERY SECTION FULLY!**



Your

Name: _____ SS#: _____ Date of Birth: _____

CONSENT FOR RELEASE OF INFORMATION BY PHONE OR VOICE MAIL – DO WE HAVE PERMISSION TO CALL:

Home Phone: (____) _____ Call your home? __Y__N Leave general information? __Y__N

Cell Phone: (____) _____ Call your cell? __Y__N Leave general information? __Y__N

Work Phone: (____) _____ Call your work? __Y__N Leave general information? __Y__N

May we contact you at your __home or __cell via our HOUSECALLS for appointment reminder? __Y__N

In case of a medical emergency whom would you like for us to contact?

Name: _____ Relationship: _____ Phone #: (____) _____

You may communicate my protected health information with the following persons: (such as spouse, parent, college student to parent, senior to adult child)

Name: _____ Relationship: _____ Phone#: (____) _____

Alternate Phone#: (____) _____

Name: _____ Relationship: _____ Phone#: (____) _____

Alternate Phone#: (____) _____

NOTE: COPC & FAMILY PRACTICE CENTER OF WESTERVILLE RESERVE THE RIGHT TO COMMUNICATE SENSITIVE HEALTH INFORMATION ONLY DIRECTLY TO THE PATIENT.

Your Signature: _____ Today's Date: _____

For office use only:

In Mysis _____ IN IC: _____ NPP Given _____