DATE	ACCOUNT NUMBER

DOCTOR	PRIMARY CARE PHYSICIAN & CITY

PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC

Use Black Ink Only

A. PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

MAIDEN/PREVIOUS NAME	ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSES NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

ADDITIONAL CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ CELLPHONE
- ☐ HOME PHONE
- ☐ E-MAIL
- ☐ TEXT

RACE
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HAWAIIAN OR PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER
- ☐ UNKNOWN
- ☐ DECLINED

ETHNICITY
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ UNKNOWN
- ☐ DECLINED

LANGUAGE
- ☐ ARABIC
- ☐ CHINESE
- ☐ ENGLISH
- ☐ FRENCH
- ☐ JAPANESE
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ UNKNOWN
- ☐ DECLINED

B. PERSON RESPONSIBLE FOR PAYMENT - IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS

C. INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT:

SIGNATURE _____ DATE _____