AULTMAN ORRVILLE ENDOCRINOLOGY
Dr. C.E. Smith, Dr. Kalpana Raghunathan
830 South Main Street, Suite 101
Orrville, Ohio 44667

Last Name: _____First Name_____M _____

Date of Birth: _____/_____/_____ SS# _____-_____-_____ Marital Status M S D W

Address_____City_____State_____ Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Employer_____ Occupation_____

Spouses' Name_____Phone_____Employer_____

E-MAIL ADDRESS:_____ _____
PHARMACY NAME AND PHONE_____

How did you hear about our practice? Please select all that apply:
Physician Referral_____Internet_____ Print Advertisement_____Billboard_____
Direct Mail/Postcard_____Facebook_____Google/online search_____Event or Health Fair_____
Word of Mouth_____Other_____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVES_____YES _____NO

- **If you do please provide the secretary with a copy for your records.**

INSURANCE INFORMATION

Primary _____ Policy _____Grp_____
Subscriber Name_____SS#_____DOB_____
Relationship to patient: Self Spouse Parent Child Other _____

Secondary_____ Policy _____Grp_____
Subscriber Name_____SS#_____DOB_____
Relationship to patient: Self Spouse Parent Child Other _____

EMERGENCY CONTACT
Name_____Phone_____Relationship_____

***If there is anyone you wish to be able to receive your Protected Health information please list below:**

Name_____ Relationship_____
Name_____ Relationship_____

- **Patients aged 17 and under must be accompanied by a parent or guardian to be treated, or signed consent to treat a minor must accompany the patient at the time of treatment.**
- **Co-pays are due at the time of your appointment.**
- **If your insurance does not authorize these services for payment, you must accept full responsibility for payment. If there is an error in the insurance information you provide us, you are financially responsible for costs not covered as a result.**
- **When contacting the office after hours there will be instructions for reaching the physician on call in case of an emergency. *THIS IS NOT TO BE USED FOR PRESCRIPTION REFILLS. REFILLS WILL NOT BE CALLED IN AFTER HOURS.**

<u>Your signature below will authorize:</u>

> Treatment by Aultman Internal Medicine Center Dr. Richard Jones

> Release of medical records and information to the insurance company/third party administrators for payment.

> The use of your personal information including but not limited to your home Phone, cell phone and address for the purpose of collecting payment for Services provided.

_____ _____

Signature **Date**

_____ _____

Parent or Guardian Signature **Date**

_____

Relationship to Patient