THE AFFINITY CENTER
REGISTRATION

7826 COOPER ROAD, CINCINNATI, OHIO 45242 TEL (513)984-1000, FAX (513)985-2182

PERSONAL INFORMATION:

CLIENT NAME_____ MARITAL STATUS_____ TODAY'S DATE_____

DATE OF BIRTH_____AGE_____ CLIENT'S SOCIAL SECURITY #_____

REFERRED BY_____

IF CLIENT IS A MINOR: PARENT'S NAMES: MOTHER_____

FATHER _____

IF PARENTS ARE SEPARATED/DIVORCED: CUSTODIAL PARENT_____

CHILD'S PRIMARY RESIDENCE IS WITH: _____MOTHER _____FATHER _____BOTH

AUTHORITY TO MAKE MEDICAL DECISIONS: _____MOTHER _____FATHER _____BOTH

PRIMARY ADDRESS_____

CITY/STATE_____ZIP CODE_____

TELEPHONE(S): PREFERRED_____ MAY WE LEAVE A MESSAGE AT THIS NUMBER? YES NO

OTHER_____

SECONDARY ADDRESS_____

CITY/STATE_____ZIP CODE_____

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN_____

STREET ADDRESS_____

CITY/STATE_____ZIP CODE_____PHONE_____

INSURANCE INFORMATION:

DO YOU WANT THE AFFINITY CENTER TO PRINT A CLAIM FORM SO THAT YOU MAY FILE WITH YOUR INSURANCE COMPANY FOR REIMBURSMENT? _____YES _____NO

IF YES, PLEASE MAKE CERTAIN TO PRESENT YOUR INSURANCE CARD TO THE FRONT DESK FOR COPYING.

_____ _____ _____

SIGNATURE RELATIONSHIP TO CLIENT DATE

REVISED 05/20/2014

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL