UC Health Center for Reproductive Health

UC Health Physician Office South
7675 Wellness Way, Suite 315
West Chester, Ohio 45069

The Christ Hospital
2123 Auburn Avenue, Suite A43
Cincinnati, Ohio 45219

P: (513) 475-7600

Patient Demographics

(Please Fill Out Completely)

CONTACT INFORMATION

Home Phone ________________________ Work Phone _______________________ Cell Phone _____________________

Pharmacy Name and Number ________________________________

May we release confidential information/test results to your partner: Yes / No

May we leave confidential messages on answering machines at: Home: Yes / No **Work:** Yes / No **Cell:** Yes / No

PATIENT'S INFORMATION

First Name ______________________________ Middle ________________ Last __________________________________

Street __________________________________ City ___________________ State______________ Zip ________________

County: Hamilton Clermont Butler Warren Kenton Boone Campbell Other: _______________________

Maiden Name ________________ Date of Birth ______________ SS# ____________________ Race ________________

Name you go by if other than above ___________________ Marital Status ____________

Alternate Contact Name________________________________ Relationship to Patient ______________________________

Street __________________________ City _____________ State ______ Zip _______ Phone Number ________________

Patient's Employer ____ Occupation ______________________________

Street _________________________ City _____________ State ______ Zip _______ Phone Number _________________

Employment Status: Full-time Part-time Self-employed Not employed Active Military Retired

Primary Care Physician _______________________________ Referring Physician __________________________________

INSURANCE INFORMATION

Primary Ins. _________________________ Policy # ___________________ Group # __________ Eff. Date ___________

Street _________________________ City _____________ State ______ Zip _______ Phone Number _________________

Secondary Ins. ______________________ Policy # __________________ Group # __________ Eff. Date _____________

Name of Policyholder____________________________________ Relationship to patient_____________________________

Patient's Signature ____ Date __________________________________

Revised January 7, 2014

SPOUSE / PARENT INFORMATION:

First Name ______________________ Middle ______________ Last ____

Street _______________________ City _____________ State ______ Zip _______ Phone Number _______________

Name you go by if other than above _______________Date of Birth _______________ SS# ______________________

Marital Status ____________ Religion ______________ Primary Care Physician _________________________________

Employer __________________________________ Occupation ____

Street _________________________ City _____________ State ______ Zip _______ Phone Number _______________

Occupation _________________________________ Status of Employment ____________________________________

Spouse's Signature (if infertility visit)___________________________________ Date __________________________

SPOUSE / PARENT INSURANCE INFORMATION:

Primary Ins. _______________________ Policy # __________________ Group # __________ Eff. Date ___________

Street ___________________________ City _____________ State ______ Zip _______ Phone Number______________

Secondary Ins. _____________________ Policy # _________________ Group # __________ Eff. Date _____________

Name of Policyholder__________________________________ Relationship to patient____________________________