PRE-REGISTRATION form

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Pre-Registration at The Ohio State University Wexner Medical Center

The Ohio State University Wexner Medical Center offers pre-registration to help make things easier when you arrive at the hospital. Pre-registrations should take only 10 minutes of your time.

You can complete the pre-registration process by:

- Calling us at **614-293-8200** between the hours of 8 a.m. and 5 p.m. Monday - Friday
- Completing and returning the form below.

If using the printed form, please fill it out completely and return it to:
The Ohio State University Wexner Medical Center
Pre-Registration
410 W. 10th Ave.
Columbus, OH 43210-9908

OSUMyChart

Are you currenlty a member of the OSUMyChart program? ❑ yes ❑ no

If you are not, would you like to be? ❑ yes ❑ no

Reason for visit (Please answer only one of the options listed below)

Is the reason for your visit related to pregnancy? ❑ Yes ❑ No Expected Due date ____/_____/_____

Is the reason for your visit a work-related accident? ❑ Yes ❑ No ❑ Work ❑ BWC

Date and time of injury: ____/____/____ ______:______

Location of the accident, please be specific: ____________________

Employer name at the time of the accident: ____________________

Job title: ____________________

Street address: ____________________

City: ____________________ State: ___________ ZIP Code: ____________________

Is the reason for your visit related to an accident? ❑ Yes ❑ No ❑ Auto ❑ Crime ❑ Other

Date and time of injury: ____/____/____ ____:_____

Location of the accident, please be specific: ____________________

Is someone else responsible for the accident? ❑ Yes ❑ No

Is the reason for your visit related to an illness? ❑ Yes ❑ No

Date and time symptoms began: ____/____/____ ______:______

Registration Form

Patient's MRN: ________________ Social Security number:_________________________ Birthdate: _____/_____/_____

Patient's last name: ____ ______ First: ____________________________

Middle initial: ______ Suffix: ❑ Jr. ❑ Sr. Sex: ❑ Male ❑ Female

Maiden name:____

Marital status: ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Preferred language: ____

❑ Intepreter requested

Religious preference:____

Religious choices: ____

Street address: ____

City: ____ State: __________ ZIP Code: ____________________

Home phone no: ____________________________________ Cell phone no: ________________________________

Email Address: ____

IN CASE OF EMERGENCY & Next of Kin Information

Name of contact: ____

Relation to patient: ____

Choices: ____

Best phone number: ____

Street address: ____

City: ____ State: __________ ZIP Code: ____________________

Name of contact: ____

Relation to patient: ____

Choices: ____

Best phone number: ____

Street address: ____

City: ____ State: __________ ZIP Code: ____________________

***Please be advised that if you are under 18 years of age, your legal guardian will be contacted by the facility to obtain consent for treatment.

Employer and School information

Patient employment status: ❑ Full ❑ part-time ❑ unemployed ❑ retired/disabled/school/never worked

Employer name: ____

Work phone number: ____________________

Employer size over 100 employees: ❑ Yes ❑ No

Street address: ____________________

City: ____________________ State: __________ ZIP Code: ____________________

If retired or disabled, the last day you stopped working: _______/_______/_______

Spouse employment status: ❑ Full ❑ part-time ❑ unemployed ❑ retired/disabled/school/never worked

Employer name: ____________________

Work phone number: ____________________

Employer size over 100 employees: ❑ Yes ❑ No

Street address: ____________________

City: ____________________ State: __________ ZIP Code: ____________________

If retired or disabled, the last day you stopped working: _______/_______/_______

Physician Information

Primary care physician: ____________________

Phone number:____________________

Street address: ____________________

City: ____________________ State: __________ ZIP Code: ____________________

Obstetrician: ____________________

Phone number: ____________________

Street address: ____________________

City: ____________________ State: __________ ZIP Code: ____________________

Referring physician: ____________________

Phone number: ____________________

Street address: ____________________

City: ____________________ State: __________ ZIP Code: ____________________

INSURANCE AND BILLING INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No If you do not have insurance, would you like to speak with someone regarding payment plan and financial assistance options that may be available for you? ❑ Yes ❑ No

Person responsible for bill if other than the patient:

Last name: ____________________ ______ First: ____________________ Middle initial: ______

Suffix: ❑ Jr. ❑ Sr. Sex: ❑ Male ❑ Female Relationship: ____________________

Security number: ____________________ Birthdate: _____/_____/_____

Street address: ______________________________

City: ______________________________ State: __________ ZIP Code: ______________

Home phone no: ______________________ Cell phone no: ______________________

Email Address: ______________________________

Insurance Coverages (Copayments will be requested at the time of service)

Name of primary insurance company: ______________________________

Name of employer or company provider: ______________________________

Insurance phone number: ________________ Policy #______________ Group #____________

Insurance street address: ______________________________

City: ______________________________ State: __________ ZIP Code: ______________

Card holder's last name: ______________________ First: ______________________

Middle initial: ______ Suffix: ❑ Jr. ❑ Sr. Sex: ❑ Male ❑ Female Patient's relationship to cardholder: ❑ Self

Social Security number: ______________________________ Birthdate: _______/_______/_______

Name of secondary insurance company: ______________________________

Name of employer or company provider: ______________________________

Insurance phone number: ________________ Policy #______________ Group #____________

Insurance street address: ______________________________

City: ______________________________ State: __________ ZIP Code: ______________

Card holder's last name: ______________________ First: ______________________

Middle initial: ______ Suffix: ❑ Jr. ❑ Sr. Sex: ❑ Male ❑ Female Patient's relationship to cardholder: ❑ Self

Social Security number: ______________________________ Birthdate: _______/_______/_______

If you have Medicare as one of your coverages, please answer the following questions:

How are you eligible for Medicare? ❑ Yes ❑ No Age: __________

Disability ❑ Yes ❑ No ❑ End stage renal disease (kidney failure)

If your eligibility is due to end stage renal disease, have you received maintenance dialysis? ❑ Yes ❑ No

Date your dialysis began ______/______/______

If your eligibility is due to end stage renal disease, have you performed self-dialysis? ❑ Yes ❑ No

Date of self- dialysis training ______/______/______

Are you currently within your 30 month coordination of benefit period? ❑ Yes ❑ No

Additional Coverages

Are you currently covered by Black Lung Benefits? ❑ Yes ❑ No

Is your appointment covered by a government (not Ohio State) research program? ❑ Yes ❑ No

Name of the program if possible: ______________________________

Is your appointment covered by the Veterans' Administration? ❑ Yes ❑ No