Oxford Family Practice
5237 Morning Sun Rd Oxford, OH 45056
513-523-7511

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: M □ F □ Social Security #_____

Billing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □

Employer: _____ Employment Status: Full Time □ Part-Time □

Self Employed □ Retired □ Not Employed □ Military Duty □

Emergency Contact: _____ Telephone: _____

Relationship: _____

Responsible Party

(Complete Only if Patient is Not the Responsible Party)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex (M/F): _____ Relationship to Patient: _____

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber_____

Effective Date of Primary Insurance: _____

Secondary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Secondary Insurance: _____

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Demographic Information Request

To comply with federal regulations, we are required to ask you for the following information:

Race Ethnicity

□ American Indian or Alaska Native □ Hispanic or Latino

□ Asian □ Not Hispanic or Latino

□ Black or African American □ Patient Declined

□ Native Hawaiian or Other Pacific Islander

□ White

□ Patient Declined

Communication Preferences

I understand that the staff and/or physicians of Oxford Family Practice may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred method for communication: □ Home □ Work □ Cell

Can we leave a message on machine or with whoever answers? (Circle Yes or No) Home Y / N Work Y / N Cell Y / N

DO NOT CALL: □ Home □ Work □ Cell

How did you hear about us?

Please check as many corresponding boxes that apply:

Website □ Facebook □ Google/Yahoo/Bing □ Other Internet Ad □

Newspaper/Magazine Ad □ Direct mailing (letter, post card, etc.) □

Friend or family_____ □ Physician □ Other (e.g., CVS) _____ □

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HIPPA Disclosure to Designated Family/Friends/Caregivers

I allow Oxford Family Practice to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

Full Name: _____ Date of Birth: _____

Phone Number: _____ Relationship: _____

Full Name: _____ Date of Birth: _____

Phone Number: _____ Relationship: _____

Full Name: _____ Date of Birth: _____

Phone Number: _____ Relationship: _____

Full Name: _____ Date of Birth: _____

Phone Number: _____ Relationship: _____

Patient Name (printed): _____

Patient Signature: _____

Today's Date: _____

Patient Name: _____ Date of Birth: _____

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Medical History

Current Medication List

Name	Dose	Frequency	Start Date	Purpose

Surgical Procedures List

Date	Procedure	Physician	Hospital

If you know the date for any of the following, please list it along with Physician and Location if known

Colonoscopy	
Mammogram	
COVID19 Vaccination (Brand)	
Flu Shot	
Tetanus Shot	
Full Blood Work Panel	

Smoking Status

Please indicate your smoking history:

□ Never Smoked □ Past Smoker □ Current smoker – Indicate how many and how often you smoke

_____

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Oxford Family Practice Office Policies

- Patients arriving 15 minutes past their scheduled appointment time will be asked to reschedule
- We do ask for a 24-hour notice if you cannot keep your previously scheduled appointment. Same day cancellations or no call no show appointment may be subject to a fee of $25.00
- All insurances copays or self-pay fees are due at the time of services.
- Any returned checks from the bank will be subject to a $30.00 overdraft charge
- All FMLA and Disability paperwork requires an appointment to be filled out.
- Any patient who is receiving regularly scheduled medications will be asked to see the doctor at least once every six months. Patients may be asked to come in more often if it is necessary to the care plan developed by the provider.
- It is the patient's responsibility to provide the most current insurance information at each appointment. If balances are incurred due to invalid insurance information the patient may be responsible for the full amount of the visit.
- Medical questions will be referred to one of our experienced nurses or one of the providers. Extended phone consults or afterhours and weekend calls resulting in telephone treatment, may be billed a telephone consultation fee.
- All routine matters should be handled during regular office hours. If you believe your situation is critical, always go to an emergency room where you will receive assistance. Otherwise, call our office and your call will be returned the following business day.
- We are not a Worker Compensation doctor, so No Workers Compensation claims will be processed through this office.

I have read and understand the above policies for Oxford Family Practice and understand that I will be asked to comply with them.

Patient Name (Printed): _____

Patient Signature: _____ Todays Date: _____

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Financial Agreement

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY
    a. • I understand that I am financially responsible for my health insurance deductible, coinsurance or noncovered service.
    b. • Co-payments are due at time of service.
    c. • In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    d. • If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS I hereby authorize and direct payment of my medical benefits to Oxford Family Practice on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS I hereby authorize Oxford Family Practice to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Oxford Family Practice. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

☆Signature of Patient, Authorized Representative or Responsible Party:

☆Printed Name of Patient, Authorized Representative or Responsible Party:

☆Relationship to Patient:_____ Patients Date of Birth:_____