Falcon Health Center

838 E. Wooster St. Bowling Green, OH 43402 [Phone] 419.372.2271 [Fax] 419.354.3222

PATIENT INFORMATION

Today's Date:_____

Patient Name: _____
(Last) (First) (Middle)

Patient Birthdate: ___/___/_____ SSN: _____/___/_____ Preferred Name: _____

Birth Sex: Male Female Gender Identity: Male Female Other: _____

E-mail Address: _____

Billing Address or PO Box: _____

City: _____ State: _____ Zip:_____

Please place an X by your primary phone number

□ Home Phone: (____) _____-_____ □ Work Phone:(____) _____-_____ □ Cell Phone: (____) ____-____

Appointment Reminders: Text Messages Phone Call Both

Marital Status: Single Married Divorced Widowed

BGSU Student: □ Full Time □ Part Time □ NA

Race: Asian Black or African American Indian Multi-Racial Pacific Islander White Other

Ethnicity: Not Hispanic Hispanic

Primary Language: English Spanish Arabic French Other: _____

Employer:_____ Phone:(_____) _____-_____

□ Full Time □ Part Time □ Retired

Address: _____ City:_____ State: _____ Zip:_____

How did you hear about the Falcon Health Center? _____

Pharmacy Falcon Health Center Pharmacy Other: _____

Who is your Family Doctor: (PCP) _____

Emergency Contact

Name: _____ Relationship: _____

Primary Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Please Complete the Back of this Form

****Please present all insurance cards to the Receptionist****

Any photos of insurance cards, please e-mail to FHCQA@woodcountyhospital.org

Primary Insurance

Insurance Company: _____ Office Visit Co-Payment: $ _____

Name of Policy Holder: _____ Policy Holder Date of Birth: ____/____/____

Relationship to Patient: _____ SSN of Policy Holder: _____/____/_____

Effective: _____/_____/_____

Employer:_____

Secondary Insurance (if applicable)

Insurance Company: _____ Office Visit Co-Payment:$ _____

Name of Policy Holder: _____ Policy Holder Date of Birth:____/____/____

Relationship to Patient: _____ SSN of Policy Holder: _____/____/_____

Effective: _____/_____/_____

Employer: _____

Additional Information required (**only if the patient is a minor**) or **STUDENT**

Mother	**Father**
Name:_____	Name:_____
Date of Birth: ____/____/_____	Date of Birth: ____/____/_____
Address:_____	Address:_____
City:_____ State:____	City:_____ State:_____
Zip:_____	Zip:_____
Home Phone:_____ Cell:_____	Home Phone:_____ Cell:_____

Minor Resides with, Name:_____ Relationship_____

Would you like to enroll in the patient portal? Yes No

Email to be used: _____

Please see a receptionist for your token.

Revised 11/21/2019