James J. Barr, M.D.
Joseph Carducci, M.D.
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250 West Bridge St., Dublin, OH 43017
Ph: 614-761-2244 Fax: 614-761-2559

PATIENT REGISTRATION

LAST NAME: ______________________________ FIRST NAME: ______________________________ MI:_______

STREET ADDRESS: ____ CITY: ______________________________

STATE: _______________ ZIP CODE: ___________ DOB: _____________ AGE: _________ SEX: M _____ F: _____

TELEPHONE#: (   ) ______________________________ CELL PHONE#: (   ) ______________________________

SSN#: ______________________________________ MARITAL STATUS: S M W D OTHER: _______________

SPOUSE'S NAME: _____________________________ EMAIL ADDRESS: ___________________________________

RACE/ETHNICITY: _____________________________ LANGUAGE: _______________________________________

EMERGENCY CONTACT: ________________________ TEL#: _____________________ RELATIONSHIP: ___________

PLEASE LIST NAME OF OTHER FAMILY MEMBERS WHO ARE/WILL BE PATIENTS AT THIS OFFICE:

NAME: ____ DOB: _______________ RELATIONSHIP: ___________

NAME: ____ DOB: _______________ RELATIONSHIP: ___________

PATIENT EMPLOYER INFORMATION:

EMPLOYER NAME: ____ TEL#: (   )______________________

EMPLOYER ADDRESS: ____ OCCUPATION: ____________________

INSURED PERSON (IF NOT PATIENT)

NAME: ____ DOB: _______________ RELATIONSHIP: ___________

STREET ADDRESS: __________________________________ CITY/STATE: ___________________ ZIP: __________

RELATIONSHIP TO PATIENT: ____

INSURANCE: PLEASE PRESENT CURRENT PRIMARY AND SECONDARY (IF APPLIES) INSURANCE CARDS AT FRONT WINDOW!!!

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM, AND/OR THE RELEASE OF INFORMATION NEEDED FOR CONTINUITY OF CARE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: ____ DATE: ______________________________