

Patient Information Form – CINCINNATI CHILDREN'S HOSPITAL**Patient Information- Please provide names as they are on passport or birth certificate.**

Last Name/Surname/Family Name:		First/Given Name:	
Middle Name:	Birth Date (month/day/year):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street/house/apartment:			
City:	State:	Postal Code:	Country:
Home Phone (with country and city code):		Cell Phone (with country and city code):	
Email:			
Country of Citizenship:		US Visa Status: <input type="checkbox"/> Valid US Visa <input type="checkbox"/> Need to apply	

Reason for Inquiry

Diagnosis/Medical History:

Has your child been seen or evaluated in CCHMC or any other US Center? No Yes If yes, which center(s):

How did you find out about us?

Self My child's physician Conference Returning patient Internet Other: _____

Parent/Legal Guardian 1- Please provide names as they are on passport or birth certificate.

Last Name/Surname/Family Name:	First/Given Name:	Middle Name:
Birth Date (month/day/year):	Relationship to patient:	
Home Phone (with country and city code):	Cell Phone (with country and city code):	
Country of Citizenship:	US Visa Status: <input type="checkbox"/> Valid US Visa <input type="checkbox"/> Need to apply	
Email:		
Address (Please provide if it is different than patient):		

PLEASE COMPLETE BOTH PAGES

Parent/Legal Guardian 2- Please provide names as they are on passport or birth certificate.

Last Name/Surname/Family Name:		First/Given Name:	Middle Name:
Birth Date (month/day/year):		Relationship to patient:	
Home Phone (with country and city code):		Cell Phone (with country and city code):	
Email:			
Country of Citizenship:		US Visa Status: <input type="checkbox"/> Valid US Visa <input type="checkbox"/> Need to apply	
Address (Please provide if it is different than patient):			

Preferred spoken language: _____ Preferred written language: _____

Do the parents or guardians speak English? Yes No Some

Does the patient speak English? Yes No Some

Financial Information Please provide this information

Payment Source: Private Insurance Self-Pay My government Other: _____

Insurance Information

Primary Insurance:	Subscriber Name:	Employer Name:
Policy number:	Group number:	Phone number:

My child's physician Information- Please provide if information is available

Name of primary physician (full name):			
Phone number (with country and city code):		Fax number (with country and city code):	
Email:		Medical specialty:	
Name of Institution or Private Practice:			
Address:			
City:	State:	Postal Code:	Country:
Name of treating or referring specialist (full name):			
Phone number (with country and city code):		Fax number (with country and city code):	
Email:		Medical specialty:	
Name of Institution or Private Practice:			
Address:			
City:	State:	Postal Code:	Country: