Please send the completed form to
Email: SH-Referrals@shinc.org
Fax: 440-974-8816

New Patient Registration Form (Please print)

Patient Last Name, Patient First Name, Suffix:	**Date of Birth**:	**Social Security Number (required)**:
Mailing Address:		
City:	**State**:	**Zip Code**:
Mobile Phone: OK to leave a message? ❑ Y ❑ N OK to send text reminders? ❑ Y ❑ N	**Home Phone**: OK to leave a message? ❑ Y ❑ N	**Email Address**: OK to send emails? ❑ Y ❑ N
Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Domestic Partner	**Gender at Birth**: ❑ Male ❑ Female	**Sexual Orientation**: ❑ Lesbian/Gay ❑ Straight ❑ Bisexual ❑ Something else ❑ Don't know ❑ Choose not to disclose
Race: ❑ American Indian/Alaska Native ❑ Black/African American ❑ White/Caucasian ❑ Hispanic ❑ Native Hawaiian/Pacific Islander ❑ Asian ❑ Multiracial/Multicultural ❑ Declined/Unknown		**Primary Language**: **Translator Needed**: ❑ Y ❑ N
Any difficulty ❑ hearing, ❑ reading or ❑ writing? If checked, please explain:		
Any special communication needs or physical accommodations needed for the appointment? ❑ Y ❑ N **If yes, please explain**:		
Legal Guardian Name:	**Phone Number**:	**Email**:
Power of Attorney Name: ❑ Financial ❑ Healthcare	**Phone Number**:	**Email**:
Emergency Contact Name:	**Phone Number**:	**Relationship to Patient**:
Additional Contact Name:	**Phone Number**:	**Relationship to Patient**:

Health Insurance Information

Primary Insurance Coverage: ❑ Medicare ❑ Medicaid ❑ Other_____ **Insurance Company**:_____ **Member ID/MMIS Number**:_____ **Medicare ID Number**:_____	**Secondary Insurance Coverage**: ❑ Medicare ❑ Medicaid ❑ Other_____ **Insurance Company**:_____ **Member ID/MMIS Number**:_____ **Medicare ID Number**:_____

Monthly Income Total:	**Source of Income**:	**Household Size**:
Reason for Referral:		**Patient Discharge Date**:
Signature Health Location Requesting Services From: ❑ Ashtabula ❑ Beachwood ❑ Lakewood ❑ Maple Heights ❑ Painesville ❑ Wickliffe ❑ Willoughby ❑ SH Care at Home		

Referring Facility Information

Referring Facility:	**Contact Name**:	**Phone Number**: **Ext**:
Address:		
City:	**State**:	**Zip Code**:
Email Address:		

Okay to send Signature Health program and service updates? **Yes** ☐ **No** ☐