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

Signature HEALTH

When you need help now.®

New Patient Registration Form (Please Print)

Patient Last Name/First Name/Suffix:	**Date of Birth:**	**Social Security Number:**
Address:		
City:	**State:**	**Zip Code:**
Home Phone: **OK to leave a message:** ❑ Yes ❑ No	**Mobile Phone:** **OK to leave a message:** ❑ Yes ❑ No **OK to send text reminders:** ❑ Yes ❑ No	
Email:		**OK to send emails:** ❑ Yes ❑ No
US Citizen: ❑ Yes ❑ No	**Active Military:** ❑ Yes ❑ No **Veteran**: ❑ Yes ❑ No	
Gender Identity: ❑ Male ❑ Female ❑ Transgender Female to Male ❑ Transgender Male to Female ❑ Non-Binary ❑ Other ❑ Chose not to disclose	**Gender at Birth**: ❑ Male ❑ Female	**Sexual Orientation:** ❑ Lesbian/Gay ❑ Straight ❑ Bisexual ❑ Something Else ❑ Don't Know ❑ Chose not to disclose
Race: ❑ American Indian/Alaska Native ❑ Black/African American ❑White/Caucasian ❑ Hispanic ❑ Native Hawaiian/Pacific Islander ❑Multiracial/Multicultural ❑ Asian ❑ Declined/Unknown		**Primary Language:** Translator Needed: ❑ Yes ❑ No
Any difficulty ❑ hearing, ❑ reading or ❑ writing? If checked, please explain:		
Any special communication needs or physical accommodations needed for the appointment? ❑ Yes ❑ No If yes, please explain:		
Parent/Legal Guardian Name (if applicable):		**Phone Number:**
Emergency Contact:	**Phone Number:**	**Relationship to Client:**
Health Insurance Information **Primary Insurance Coverage:** ❑Medicare ❑Medicaid ❑Other:_____ Insurance Company: _____ Member ID/ MMIS#:_____ Medicare ID#:_____	**Secondary Insurance Coverage:** ❑Medicare ❑Medicaid ❑Other:_____ Insurance Company: _____ Member ID/ MMIS#:_____ Medicare ID#:_____	
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 ❑ Willoughby		

Referring Facility Information

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