Leahy Family Care, Inc.
825 South Cable Road, Suite A
Lima, OH 45805-3467

William J. Leahy, MD
Michelle R. Menke, NP-C
Julia A. Moore, RD LD

****PLEASE COMPLETE ALL SECTIONS ON FRONT. IF A SECTION DOES NOT APPLY, WRITE N/A.****

PATIENT INFORMATION

Full Name: (First Name) (Middle Initial) (Last Name) | SS#:

Sex (circle one): Male Female | Birth date: | Marital Status (circle one): Single Married Divorce Separated Widow(er)

Ethnicity: Hispanic __ NonHispanic __ Declined ___ | Primary Language:

Mailing Address: | City: | State: | Zip:

Home Phone: | Cell Phone: | E-mail Address:

Employment Status (circle one): Full Time Part Time Retired Unemployed Student | Employer:

Employer Address: | Employer Phone:

When trying to reach you by phone/cell, may we leave a message? (circle one) Yes No | At work? (circle one) Yes No

Spouse's Name: | Birth date: | Soc Sec #:

If Patient is a Minor or has a Guardian
Parent/Guardian's Name: | Permission to treat if parent not present: (circle one) Yes No

INSURANCE INFORMATION

NOTE: We require copies of all health insurance cards at the time of service.

SUBSCRIBER INFORMATION - PRIMARY INSURANCE

(person carrying the health insurance)

Subscriber Name: | Birth date: | Soc Sec #:

Mailing Address: | Home Phone:

Cell Phone: | Employer: | Employer Phone:

Relationship to patient: | Is the patient covered by insurance? (circle one) Yes No

SUBSCRIBER INFORMATION - SECONDARY INSURANCE

(if different than primary)

Subscriber Name: | Birth date: | Soc Sec #:

Mailing Address: | Home Phone:

Cell Phone: | Employer: | Employer Phone:

Relationship to patient: | Is the patient covered by insurance? (circle one) Yes No

Person responsible for bill:

Please list all family members on account: (cont on back side)		**Previous Physician**
		Name & Address:
		(circle one)
		Have you had your records transferred? Yes No

IN CASE OF AN EMERGENCY

Person to contact **OUTSIDE** of your household:: | Phone:

PATIENT AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Leahy Family Care, Inc. or William J. Leahy, MD. I understand that I am financially responsible for any balance. I authorize Leahy Family Care, Inc. or my insurance company to release any information required to process my claims.

Date: | **Patient/Guardian Signature:** X

FOR OFFICE USE ONLY

Application checked	_________ (Date)	_______ (Pt. initials)	Application checked	_________ (Date)	_______ (Pt. initials)
Application checked	_________ (Date)	_______ (Pt. initials)	Application checked	_________ (Date)	_______ (Pt. initials)
Application checked	_________ (Date)	_______ (Pt. initials)	Application checked	_________ (Date)	_______ (Pt. initials)

*****Only date and initial the application if *NOTHING* has changed. We require a new application if changes occur.**