Ohio Valley Manor Nursing & Rehabilitation Center

New Patient Pre-Registration

Name:

_____

Last first middle

Sex: M F **Age:** _____ **Date of Birth:** ___/___/19___ **Marital Status:** _____

Street Address:

_____

City: _____ **State:** _____ ZIP: _____ **Phone**: _____

County: _____ **Soc. Sec**: _____ - ___ - _____**Medicare** (if any): ____ - ___- ____

Ohio Medicaid Number (if any): _____ **Caseworker Name**: _____

Other Health Insurance (if any): _____ **ID Number**: _____

Physician Name: _____ **Office Phone:** _____

Emergency Contact #1 Name: _____ **Relationship to Patient**: _____

Phone Number: _____

Emergency Contact #2 Name: _____ **Relationship to Patient**: _____

Phone Number: _____

MY PREFERENCES: *[] PRIVATE ROOM [] TV [] PHONE*

(ADDITIONAL CHARGES MAY APPLY; PREFERENCES CANNOT BE GUARANTEED AND ARE BASED UPON AVAILABILITY)

_____ _____

Date completed Signature of person completing form

Thank you for pre-registering!

SACpreRegForm.doc