Ozarks Medical Center

# OMC/Zizzer Clinic

## *Student-Patient Registration Form*

**Today's Date:** _____

**Patient Name:** _____
*First* *Middle* *Last*

**Date of Birth:** _____ **Age:** _____ **SSN#:** _____ **Gender:** *Male / Female*

**Home Address:** _____
*Street* *City* *State* *Zip*

**Mailing Address:** _____
*Street* *City* *State* *Zip*

**Primary Phone:** (_____) _____ **Alternate Phone:** (_____) _____

**Email Address:** _____

**Primary Care Physician (PCP):** _____ **Pharmacy:** _____

**Parents/Legal Guardians:** _____

**Please list people we may notify in the event of an emergency** *(Please list at one contact outside of your household)*:

**Contact:** _____ **Relationship:** _____ **Phone:** _____

**Contact:** _____ **Relationship:** _____ **Phone:** _____

---

**Complete this section if the patient is a minor or if the patient is not financially responsible**

**Responsible Party:** _____ **Relationship to Patient:** _____

**Date of Birth:** _____ **Age:** _____ **SSN#:** _____ **Gender:** *Male / Female*

**Marital Status:** *Single / Married / Widowed / Divorced* **Spouse Name:** _____

**Mailing Address:** _____
*Street* *City* *State* *Zip*

**Employer:** _____ **Work Phone:** (_____) _____

Ozarks Medical Center

# OMC/Zizzer Clinic

***Student-Patient Registration Form***

## Insurance Information

**Patient Name:** _____ **Date of Birth:** _____

---

**Primary Insurance:** _____

**Address:** _____
*Street* *City* *State* *Zip*

**Group #:** _____ **Insurance ID #:** _____

**Patients Relationship to Insured:** Self / Child / Spouse / Other: _____

---

**Secondary Insurance:** _____

**Address:** _____
*Street* *City* *State* *Zip*

**Group #:** _____ **Insurance ID #:** _____

**Patients Relationship to insured:** Self / Child / Spouse / Other: _____

---

**No Insurance Coverage or Self-Pay:** _____
*Please Sign*

☐ The patient currently does not have health insurance, but I would like the OMC Coordinator to contact me and assist in enrolling in Medicaid and discussing Financial Assistance, if applicable *(Please check the box if you agree)*.

_____
*Signature of Patient and/or Responsible Party*

**Please send a copy of the insurance card or stop by the clinic, we will be happy to make a copy of the card for you.**

***It is your responsibility to notify the OMC/Zizzer Clinic if your insurance changes.***

Ozarks Medical Center

# OMC/Zizzer Clinic

***Student-Patient Registration Form***

## Student Health History

**Patient Name:** _____ **Date of Birth:** _____

---

**Person Providing Information:** _____

**Have you ever had a Well-Child checkup exam?** Yes / No **Date of most recent Well-Child:** _____

**Allergies**

Do you have any allergies? If yes, please let us know what you are allergic to and what type of reaction you have.

| Allergy | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Medications**

Are you currently taking any medications? If yes, please list medication(s), dosage(s), and frequency. *(Please attach a separate list with today's date, if more space is needed.)*

| Medication(s) | Dosage | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Have you ever had surgery or been hospitalized? If yes, please list reason and date(s).**

_____

_____

Ozarks Medical Center

# OMC/Zizzer Clinic

## *Student-Patient Registration Form*

**Patient Name:** _____ **Date of Birth:** _____

---

**Please list any conditions for which you have been treated for or are currently being treated for.**

_____

_____

_____

| **Family History** *(Please check all that apply)* | Patient | Mother | Father | Mother's Parents | Father's Parents |
|---|---|---|---|---|---|
| Alcoholism | | | | | |
| Asthma, Lung Disease | | | | | |
| Bleeding Disorders | | | | | |
| Cancer | | | | | |
| Diabetes (Specify Type) | | | | | |
| Epilepsy, Seizure Disorder | | | | | |
| Glaucoma | | | | | |
| Heart Disease | | | | | |
| High Blood Pressure | | | | | |
| Kidney Disease | | | | | |
| Mental Illness, Depression, Anxiety, ADHD, etc. | | | | | |
| Migraines | | | | | |
| Osteoporosis | | | | | |
| Stroke | | | | | |
| Thyroid Disease | | | | | |
| Other (Specify) | | | | | |
| | | | | | |

**Please list any other information you feel is pertinent to your medical care.**

_____

_____

_____

**It is your responsibility to notify the OMC/Zizzer Clinic if any of the information provided on this form becomes inaccurate or incomplete. The Student Registration form is only applicable at the OMC/Zizzer Clinic.**