Cincinnati Children's
changing the outcome together

Downtime Registration Form

Patient Label
Name: _____
DOB: _____ MRN: _____
CSN: _____

PATIENT INFORMATION

Name (Last, First, Middle)	MRN	DOB	Gender

School	Written Language	Spoken Language

Address	Religion	Ethnicity	☐ Hispanic ☐ Non-Hispanic

City, State, ZIP	Alias (if applicable)	Marital Status

Patient Phone	Patient Email

Guarantor Name	Emergency Contact Name, Phone, & Relationship to Patient

PARENT/PRIMARY CAREGIVER INFORMATION

Parent/Primary Caregiver (PC) #1 Name	Parent /Primary Caregiver (PC) #2 Name

Parent/PC #1 Address	Parent/PC #2 Address

Parent/PC #1 Phone ☐ Home ☐ Cell ☐ Work	Parent/PC #1 Phone ☐ Home ☐ Cell ☐ Work	Parent/PC #2 Phone ☐ Home ☐ Cell ☐ Work	Parent/PC #2 Phone ☐ Home ☐ Cell ☐ Work

Parent/PC #1 Email	Parent/PC #2 Email

Parent/PC #1 DOB / SSN	Parent/PC #2 DOB / SSN

Parent/PC #1 Employer	Parent/PC #2 Employer

Parent/PC #1 Spoken Language	Written Language	Parent/PC #2 Spoken Language	Written Language

PRIMARY INSURANCE

Name of Insurance Company	Policy #

Address of Insurance Company	Group #

Subscriber Name	Subscriber Employer

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Policy #

Address of Insurance Company	Group #

Subscriber Name	Subscriber Employer

Interviewer Signature/Credentials Printed Name Date/Time