Wexner Medical Center

University Reference Laboratory
680 Ackerman Road
Building 4, Room D405
Columbus, OH 43202

PATIENT INFORMATION FORM: Please Print

Patient: (if other than Guarantor)

Last Name _____ Home Phone _____
First Name _____ MI _____ Work Phone _____ Ext. _____
Street _____ Date of Birth _____ Place _____
City _____ State _____ Social Security # _____
Zip _____ Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Other ☐
Employed Yes ☐ No ☐
Employer/School _____

Guarantor Information (Person responsible for bill)

Last Name _____ Home Phone _____
First Name _____ MI _____ Work Phone _____ Ext. _____
Street _____ Date of Birth _____ Place _____
City _____ State _____ Social Security # _____
Zip _____ Sex: M ☐ F ☐ Marital Status Single ☐ Married ☐ Other ☐
Employed Yes ☐ No ☐ **Referred By**: _____
Employer/School _____

Spouse

Last Name _____ Work Phone _____ Ext. _____
First Name _____ MI _____ Date of Birth _____ Place _____
Sex: M ☐ F ☐ Social Security # _____
Employed Yes ☐ No ☐
Employer/School _____

Insurance Information

Primary Coverage _____ Secondary Coverage _____
Claim Address _____ Claim Address _____
City / State / Zip _____ City / State / Zip _____
Policyholder: Self ☐ Spouse ☐ Other ☐ Policyholder: Self ☐ Spouse ☐ Other ☐
ID # _____ ID # _____
Group # _____ Plan # _____ Group # _____ Plan # _____
Is plan through work? Yes ☐ No ☐ Is plan through work? Yes ☐ No ☐

I UNDERSTAND THAT SERVICES RENDERED TO ME MAY NOT BE ELIGIBLE FOR BENEFITS UNDER MEDICARE, MEDICAID OR OTHER INSURANCE OR PAYORS. SERVICES NOT ELIGIBLE FOR BENEFITS MAY INCLUDE TESTS AND PROCEDURES THAT ARE NOT COVERED, OR THOSE DELIVERED BY HEALTH CARE PROVIDERS WHO DO NOT PARTICIPATE WITH MY INSURANCE PLAN. NON-COVERED SERVICES MAY ALSO INCLUDE THOSE MY PHYSICIAN DETERMINES MEDICALLY NECESSARY, BUT ARE LATER DETERMINED UNNECESSARY BY MY INSURANCE PLAN. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ANY NON-COVERED SERVICE.

Legal Signature: _____ Date: _____