

*Gentle Care Health Center  
Ellen C. Spinner, MSN, CNP  
15 North Main Street  
Mechanicsburg, OH 43044*

**Patient Information**

Name (Last, First, M.I.) \_\_\_\_\_ Date \_\_\_\_\_

Address (no P.O. Boxes) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home#: \_\_\_\_\_  Ok to leave detailed message  Leave callback # only

Cell #: \_\_\_\_\_  OK to leave detailed message  Leave callback # only

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Insurance Information**

Primary Insurance Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Address \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Address \_\_\_\_\_