



Patient Registration Form

Patient's Name			Date of Birth (DOB)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
First	MI	Last	MM/DD/YY			
Address			City	State	Zip	Patient's Social Security Number
Street/Apt <input type="checkbox"/> Homeless						
Primary Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			Alternative Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
<input type="checkbox"/> Please leave a voicemail if I do not answer			<input type="checkbox"/> Please leave a voicemail if I do not answer			
Preferred Method of Contact:						
<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Letter						
Marital Status		Preferred Language		Employment Status		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> ASL <input type="checkbox"/> Other _____		<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Child		
		Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer _____		
The following information is to help better understand the needs of the communities we serve. Your information will not be shared.						
Race (check all that apply)		Sexual Orientation:		Do you live in public housing?		
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black / African American <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Multiracial <input type="checkbox"/> I decline to identify		<input type="checkbox"/> Heterosexual / Straight <input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Decline to answer		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ethnicity		Gender Identity:		Are you a Veteran?		
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refuse to provide		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male from Female <input type="checkbox"/> Transgender Female from Male <input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Are you an Agricultural, Farmer or Migrant Worker?		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Family Size: _____		
				Current Household Income: (Please complete one)		
				Annual _____		
				Monthly _____		
				Weekly _____		
How did you hear about us? <input type="checkbox"/> Insurance Company <input type="checkbox"/> Physician <input type="checkbox"/> Health Fair <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Patient <input type="checkbox"/> County / Govt. Agency _____						

PATIENT PORTAL

Now you can safely and confidentially manage some of your health care needs on My Health portal. Provide your email address below and look for an email from us to sign up.

Patient's Email Address: _____

INSURANCE INFORMATION

Is the patient the guarantor (responsible party) for the bills associated with services received? Yes No

If yes, and patient is covered by insurance that should be billed for services provided, please present the insurance card to staff and complete the following:

Medical Insurance Information

Primary Medical Insurance:	Subscribers Name:	Subscriber's SSN	Birth Date	Policy #	Group #
Secondary Medical Insurance (if applicable):	Subscribers Name:	Subscriber's SSN	Birth Date	Policy #	Group #

Patient's relationship to subscriber: Self Spouse Child Step Child Other

Dental Insurance Information

Subscribers Name:	Subscriber's SSN	Birth Date	Policy #	Group #
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Patient's relationship to subscriber: Self Spouse Child Step Child Other

EMERGENCY CONTACT

Contact Name	Relationship	Contact Phone
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GUARANTOR'S INFORMATION

Guarantor's Name	First	MI	Last	Guarantor's Date of Birth	
Guarantor's Address	Street	City	State	Zip	County
<input type="checkbox"/> Same as patient					
Guarantor's SSN	Relationship			Guarantor's Phone Number	

I give permission for Greater Baden Medical Services, Inc. to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services.

I also understand that I am responsible for any deductibles, copayments and if not covered I am responsible for the charges.

I understand that family planning services are voluntary and they are not a requirement for other GBMS services.

To the best of my knowledge, the above information is correct. I understand that if any of the above information changes, I will notify the Center as soon as possible.

I understand by signing this form I am granting permission for treatment for the patient.

Signature of Patient or Responsible Party

Date