GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

Patient Registration Form

Patient's Name First MI Last

Date of Birth (DOB) MM / DD / YYYY

☐Male ☐Female

Address Street/Apt ☐Homeless

City

State

Zip

Patient's Social Security Number

Primary Phone ☐ Cell ☐ Home ☐ Work

☐ Please leave a voicemail if I do not answer

Alternative Phone ☐ Cell ☐ Home ☐ Work

☐ Please leave a voicemail if I do not answer

Preferred Method of Contact:

☐ Can Send Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Letter ☐ Can Send Mail with Return Address

Marital Status
☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Widowed ☐ Domestic Partner

Rx History Consent
I authorize GBMS to view my external prescription history via eCW.

☐ Yes, signed form attached. ☐ Declined

Preferred Language
☐ English
☐ Spanish
☐ ASL
☐ Other _____

Do you need an interpreter?
☐ Yes ☐ No

Employment Status
☐ Employed full-time ☐ Not employed
☐ Employed part-time ☐ Self-employed
☐ Retired ☐ Child

Employer _____

Student Status
☐ Full-time student ☐ Not a student
☐ Part-time student

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)
☐ Black / African American
☐ White
☐ American Indian / Alaska Native
☐ Asian Indian ☐ Other Asian
☐ Chinese ☐ Japanese ☐ Filipino
☐ Korean ☐ Vietnamese
☐ Native Hawaiian ☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander
☐ Other _____
☐ Multiracial ☐ Decline to Specify

Ethnicity
Are you Hispanic, latino/a, or Spanish Origin? (One or more categories may be selected)
☐ No, not of Hispanic/Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Other Hispanic, Latino/a or Spanish origin
☐ Yes, Puerto Rican ☐ Yes, Cuban
☐ Decline to Specify

Sexual Orientation
What sex were you assigned at birth?
☐ Male ☐ Female
☐ Other / Intersex

Pronoun Preference:
☐ He/Him ☐ She/Her
☐ They/Them/Us
☐ Other _____

What is your Gender Identity:
☐ Male ☐ Female
☐ Male to Female Transgender Male
☐ Female to Male Transgender Female
☐ Genderqueer (Neither male nor female)
☐ Do not want to disclose

What is your sexual orientation?
☐ Straight / Heterosexual
☐ Lesbian / Gay / Homosexual
☐ Bisexual ☐ Do not know
☐ Other
☐ Do not want to disclose

Do you live in public housing?
☐ Yes ☐ No

Are you a Veteran?
☐ Yes ☐ No

Are you an Agricultural, Farmer or Migrant Worker?
☐ Yes ☐ No

Family Size: _____

Current Household Income:
(Please check one)
☐ Under - $19,999
☐ $20,000 - $29,999
☐ $30,000 - $39,000
☐ $40,000 - $49,000
☐ $50,000 - $59,999
☐ $60,000 - $79,999
☐ $80,000 +
If annual income is unknown, please provide weekly or monthly income below:

$_____Weekly

$_____Monthly

How did you hear about us? ☐ Insurance Company ☐ Physician ☐ Health Fair ☐ Hospital _____
☐ Friend ☐ Website ☐ Patient ☐ County / Govt. Agency _____

PATIENT PORTAL

Now you can safely and confidentially manage some of your health care needs on the eClinicalWorks Patient Portal. Please provide your email address below.

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

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

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

Dental Insurance Information

Insured Name:	Insured's SSN	Birth Date	Policy #	Group #/ Group Name

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

EMERGENCY CONTACT

Contact Name- ☐ **Contact knows patient is being seen**	Relationship	Contact Phone

GUARANTOR'S INFORMATION

Guarantor's Name First	MI	Last	***Guarantor's Date of Birth***

Guarantor's Address Street ☐ Same as patient	City	State	Zip	County

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