GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

Patient Registration Form

Patient's Name First	MI	Last	**Date of Birth (DOB)** MM/DD/YY	☐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:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Letter

Marital Status

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

Preferred Language

☐ English
☐ Spanish
☐ ASL
☐ Other _____

Do you need an interpreter?

☐ Yes ☐ No

Employment Status

☐ Employed ☐ Unemployed
☐ Retired ☐ Child

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)

☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black / African American
☐ White
☐ Other _____
☐ Multiracial
☐ I decline to identify

Ethnicity

☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Refuse to provide

Sexual Orientation:

☐ Heterosexual / Straight
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Other
☐ Decline to answer

Gender Identity:

☐ Male
☐ Female
☐ Transgender Male from Female
☐ Transgender Female from Male
☐ Gender non-conforming
☐ Other

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 complete one)
Annual _____
Monthly _____
Weekly _____

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 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 #

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

EMERGENCY CONTACT

Contact Name	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