PATIENT REGISTRATION FORM

***=Required Field for EMR**

PATIENT INFORMATION

*Last Name: ___________________________________ *First Name: __________________________M.I.____ Pronoun: __________

Former Name: _________________*Gender Identity: _______________*Birth Sex: _________*Date of Birth:________________

*Mailing Address:____

Street Address (if different than mailing):____

*City:____*State:_________________________*Zip code:_________________

Home Phone #: ________________________Mobile/Cell Phone #: ________________________Work Phone: ___________________

*Preferred Phone Contact: **HOME** **MOBILE/CELL** **WORK** **(*circle*)**

May we leave a message with appointment information **YES___NO___** Medical information **YES___NO___?** ***(circle)***

*Email Address:____

*Race(s)____________________________________ Ethnicity: Hispanic/Latino Not Hispanic/Latino Refused Unknown ***(circle)***

*Marital Status: _______________________ Primary Language________________________Religion___________________________

Primary Care Provider _______________________________Referring Provider (if not primary care doctor) ______________________

Preferred Pharmacy: ______________________________________ Location: ____

EMPLOYER INFORMATION

*Employment Status: Full time Part time Not employed Disabled Retired Student Self Employed ***(circle)***

*Retirement/Disability Date (if applicable): _______________________

Employer:____Occupation:_______________________________________

Address:____

State:_______________________________Zip: ____________________________Phone:____

GUARANTOR/ CONTACT INFORMATION

Guarantor Name:____DOB:___________________Phone #:__________________________

Relationship to Patient: _____________________________________

*Emergency Contact: _____________________________________ DOB: __________________ *Phone:___________________________

*Relationship to Patient: __________________________________

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INSURANCE INFORMATION

***Primary Insurance:____**

*Primary Insured Name:_____________________________*DOB:__________________

*Relationship to Patient:_____________________*Policy #:________________________

Group #:_________________________Effective Date:___________Expiration Date:_______

Secondary Insurance:____

Secondary Insured Name:____________________________DOB:___________________

Relationship to Patient:______________________Policy #:_________________________

Group #:_________________________Effective Date:__________ ExpirationDate:_______

***Is this Worker's Comp./Motor Vehicle Accident or Other Liability Claim?** ______If Yes, date of injury__________

Claim #______________________Contact Name/Case Worker:_____________________

Liability Insurance Name:____________________Phone #________________________

Address:____

I do hereby consent to and authorize the performance of all treatments and medical services by the staff of Grace Cottage Family Health & Hospital and its team which they deem advisable. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. Grace Cottage Family Health & Hospital will bill my insurance if applicable, on my behalf. I hereby authorize Grace Cottage Family Health & Hospital to release information requested by insurance company and/or its representative.

***SIGNATURE:________________________________DATE:____________________**

***Name (Print):______________________________Relationship to patient:____________**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Grace Cottage Family Health & Hospital Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we will provide you, the notice is also available on our website @:https://gracecottage.org/patients-visitors/notice-of-privacy-practices

***SIGNATURE:_______________________________*DATE:____________________**

***Name (Print):______________________________Relationship to Patient:____________**