GRAND TRAVERSE
Women's Clinic

PATIENT REGISTRATION FORM (PLEASE PRINT)

Date:		Primary Care Provider Name:	
Last name:	First:	Middle:	Marital status: **M** ☐ **S** ☐ **D** ☐ **W** ☐
Is this your legal name? Yes ☐ No ☐	If not, what is your legal name?	Birth date: / /	Age:
Street Address:	P.O. Box	Phone #: H: ( ) C: ( )	
City:	State: Zip:	Preferred Contact #: Home ☐ Cell ☐ ☐Work	
Social Security #:	Race:	Ethnicity: Hispanic ☐ Non-Hispanic ☐	
Employer:	FT: ☐ PT: ☐	Work phone: ( )	
***Used for Patient Portal only** ***Email:**		Referred to clinic by:	

Pharmacy Preference/location:_____

May we leave a message on your answering machine? ☐YES ☐NO

Who may we release health information to? _____Relationship_____

☐ **Do not release health information without consent**

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Name of Primary Insurance :

Subscriber's name:	Birth date: / /	Phone #:	Policy #:	Group #:
Patient's relationship to subscriber ☐Self ☐Spouse ☐Child ☐Other			Copay amount:	
Employer:	Employer Address:			

Name of *Secondary Insurance* (if applicable):

Subscriber's name:	Birth date: / /	Phone #:	Policy #:	Group #:
Patient's relationship to subscriber ☐Self ☐Spouse ☐Child ☐Other			Copay amount:	
Employer:	Employer Address:			

IN CASE OF EMERGENCY

Name of contact:	Relationship to patient:	Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Grand Traverse Women's Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	Date: