### 

# PATIENT REGISTRATION FORM (please Print)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date: | Primary Care  Provider Name: | | | | Referred to clinic  by: | | | | | | |
| Legal Last name: | | First Name: | | | | | | | Middle: | | |
| Birth date: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_ | | Marital status:  **M**  **S**  **D**   **W** | | | | **SS #:** | | | | | |
| Street Address: | | P.O. Box: | | Phone #:  H: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_  C: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_  W: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **Preferred Contact #:**  Home  Cell  Work | |
| City: | | State: Zip: | |
| **\*Used for Patient Portal only \* Email address:** | | | | | | | | | | | |
| **Legal sex:** (sex on driver’s license or on record with insurance company)  ☐ Female  ☐ Male | | **Pronouns** (check all that apply):  ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ Not listed (please specify): \_\_\_\_\_\_\_\_\_\_\_\_ ☐ Prefer not to answer | | | | **Sexual identity** (check all that apply)  ☐ Straight/heterosexual ☐ Polysexual  ☐ Lesbian ☐ Pansexual ☐ Gay ☐ Asexual  ☐ Homosexual ☐ Queer ☐ Bisexual ☐ Unsure  ☐ Not listed (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| What is your current **gender identity**? (Check ALL that apply)    ☐ Male ☐ Female ☐ Gender Queer ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF  ☐ Additional category (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Decline to answer | | | | | | | | | | | |
| Race: | | Ethnicity: ☐ Hispanic ☐ Non-Hispanic | | | | | | | | | |
| INSURANCE INFORMATION (Please give your insurance card to the receptionist.) | | | | | | | | | | | |
| **Name of Primary Insurance** **:** | | | | | | | | | | | |
| Subscriber’s name: | | Birth date:  / / | Ph. #: | | | | Policy #: | | | | Group #: |
| Patient’s relationship to subscriber Self Spouse Child Other | | | | | | | Copay amount: | | | | |
| **Name of *Secondary Insurance* (if applicable):** | | | | | | | | | | | |
| Subscriber’s name: | | Birth date:    / / | Ph. #: | | | | Policy #: | | | | Group #: |
| Patient’s relationship to subscriber Self Spouse Child Other | | | | | | | Copay amount: | | | | |
| Preferred Pharmacy & location of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  May we leave a message on your answering machine?  YES  NO  Person/s we may release your protected health information to: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do not release protected health information without consent** | | | | | | | | | | | |
| 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: | | | | | | | |