###

# PATIENT REGISTRATION FORM (please Print)

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| --- | --- | --- |
| 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 [ ]  NOPerson/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: |