**GREATER BADEN MEDICAL SERVICES, INC.**
**Registration Form**

## Section I – Patient Information:

_____ _____
Patient's Social Security Number Today's Date

_____ _____ _____ _____
Patient's Last Name First Name Initial Suffix (ex. Sr, Jr, II)

_____
Patient's Address

_____ _____ _____
City State Zip Code

_____ _____
Patient's Home Telephone Number If Applicable – Patient's Work Telephone Number

Male Female _____ _____
Circle Patient's Sex Patient's Date of Birth If Applicable – Name of Patient's Employer

_____ _____
Patient's E-Mail Address If Known, Please Enter Provider the Patient Has Seen or Will Be Seeing

Circle Patient's Marital Status: Single Married Divorced Widowed Separated

Circle Patient's Employment Status: Full Time Part Time Not Employed Self Employed

Retired Military Duty

Circle Patient's School Status: Full Time Part Time Not A Student

If the patient is not the responsible party (guarantor) for the bills associated with services received, please complete the following:

_____ _____ _____ _____
Responsible Party Last Name First Name Initial Suffix

_____
Responsible Party's Address

_____ _____ _____
Responsible Party's City State Zip Code

_____ _____
Responsible Party's Social Security Number Responsible Party's Home Phone Number

_____
Responsible Party's Date of Birth

In case of an emergency, please provide the following information:

_____ _____
Contact Name Contact Phone Number

If you do not have a contact person, please indicate so here. _____

**PLEASE COMPLETE BACK OF FORM**

Is the patient covered by a third party payor (Medicaid, Blue Cross, Medicare, Commercial Insurance) that should be billed for services provided? _____Yes _____ No

**If the answer if no**, please skip Section II and complete the questions in Section III - "Additional Patient Information Section".

## Section II - Insurance Information:

_____ Self Spouse Child Other

Subscriber's Name — Circle the Relationship to the Patient

_____ _____

Name of Insurance Company — Identification Number

_____ _____

Group Name — Group Number

_____

Subscriber's Date of Birth

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## Section III - Additional Patient Information:

**Please Circle the Patient's Race**

Asian Native Hawaiian Other Pacific Islander Black/African American (Not Hispanic or Latino)
American Indian/Alaskan Native White (Not Hispanic or Latino) Hispanic or Latino (All Races) More Than One Race

**Please Circle the Patient's Ethnicity**

Hispanic/Latino Non Latino

What language is spoken at home? _____

If the patient has been here before, did they have a different name? If so, please enter that name
_____

Is the patient a Veteran? _____Yes _____No

Is the patient a Migrant Worker? _____Yes _____No

Is the patient Homeless? _____Yes _____No

Does the patient require translation services? _____Yes _____No

If we need to contact the patient may we do so by the following means?

Telephone Call _____Yes _____No

Telephone Message _____Yes _____No

Mail _____Yes _____No

E-Mail _____Yes _____No

To the best of my knowledge, the above information is accurate. I understand that if any of the above information changes, I will notify the Center as soon as possible.

_____ _____

Signature of Patient or Responsible Party — Date