GREATER BADEN MEDICAL SERVICES, INC.
Registration Form

Patient Information:

Today's Date ______________________

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

Date of Birth ______

Patient's Address

Street ______

City ______ State ______ Zip Code ______

Patient's Primary Telephone Number ______ ☐ Cell ☐ Home ☐ Work ☐ None

Patient's Alternate Telephone Number ______ ☐ Cell ☐ Home ☐ Work ☐ None

Is it ok to call Primary Phone ☐ Yes ☐ No Ok to leave message ☐ Yes ☐ No

Is it ok to call AlternativePhone ☐ Yes ☐ No Ok to leave message ☐ Yes ☐ No

Sex: ☐ Male ☐ Female **Patient's Social Security Number** ______

Current household annual income	**Employment status**	**Racial Group(s)**	**Ethnicity**
☐ < $10,000 ☐ $10,000 to $14,999 ☐ $15,000 to $19,999 ☐ $20,000 to $29,000 ☐ $30,000 to $49,000 ☐ $50,000 to $79,000 ☐ > $80,000 ☐ Choose not to disclose	☐ Employed ☐ Unemployed ☐ Retired ☐ Child **Employer Name** ______ ______ ______	☐ American Indian/ Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ White ☐ Other ☐ Multiracial ☐ I decline to identify my Race	☐ Hispanic/Latino ☐ Non-Latino **Language** ☐ English ☐ Spanish Other ______
Do you think of yourself as: ☐ Heterosexual/straight ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Other ☐ Unknown ☐ Choose not to disclose	**What is your current gender identity?** ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Genderqueer, neither exclusively male nor female ☐ Other ☐ Choose not to disclose	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown or other **Family Size** ______ **Veteran Status** ☐ Veteran ☐ Not a Veteran	**Do you live in public housing?** ☐ Yes ☐ No **Are you an Agricultural, Farmer or Migrant Worker?** ☐ Yes ☐ No

How did you hear about us? ☐ Insurance Company ☐ Physician ☐ Health Fair ☐ Patient ☐ Friend
☐ Website ☐ Charles Regional Medical Center ☐ Area on Aging 60+

Greater Baden Patient Portal: Now you can safely and confidentially manage some of your health care needs on ***My Health*** portal. Please provide your email address below and look for an email from us to sign up.

Patient's E-Mail Address ______________________________

Preferred method of contact ☐ Letter ☐ Cell ☐ Home # ☐ Work # ☐ Email ☐ None

Insurance Information:

Is the patient the guarantor (responsible party) for the bills associated with services received ☐ Yes ☐ No

If yes, and patient is covered by insurance that should be billed for services provided,
Please present this insurance card to staff and fill out the following.

______________________ Self Spouse Child Other
Subscriber's Name — Circle the Relationship to the Patient

______________________ ______________________
Subscriber's Date of Birth — Subscriber's Date of Birth

If no, please complete the following:

Guarantor's Information:

Guarantor's First Name ________ Initial ________ Last Name ________ Suffix (ex. Sr, Jr, II) ________

Street ______________________________

City ________ State ________ Zip Code ________

Guarantor's Date of Birth ________

Guarantor's Primary Telephone Number ______________ ☐ Cell ☐ Home ☐ Work ☐ None

Guarantor's Alternate Telephone Number ______________ ☐ Cell ☐ Home ☐ Work ☐ None

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

Contact Name ______________ Contact Phone Number ☐ Cell ☐ Home other__________

I give permission for Greater Baden Medical Services, Inc. to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services.

I also understand that I am responsible for any deductibles, copayments and if not covered I am responsible for the charges incurred.

I understand that family planning services are voluntary and they are not a requirement for other GBMS services.

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.

I understand by signing this form I am granting permission for treatment for the patient.

______________________________ ______________
Signature of Patient or Responsible Party — Date