Patient Registration Form

Patient Information

Patient Information			
Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Family Physician or Pediatrician:	Date of Birth:		Sex: ☐ M ☐ F
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:		Relationship to Patient:	

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**			
E-mail Address:			**Can we leave a message regarding your medical care & test results?**
Race (please select):			**Ethnicity (please select one):**
o White	o American Indian or Alaska Native	o Asian	o Hispanic or Latino
o Hispanic	o Black or African American	o Native Hawaiian or Pacific Islander	o Not Hispanic or Latino
o Other	o Decline		o Decline
Preferred Language (please select one):	o English	o Bosnian	o Indian (including Hindi & Tamil)
	o Sign Language	o Spanish	o Russian o Other
Preferred Pharmacy Name & Location:			

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Gift of Health Medical (GOHM) payment policy. I am eligible for the insurance indicated on this form, and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to GOHM all money to which I am entitled for medical expenses related to the services performed from time to time by GOHM, but not to exceed my indebtedness to GOHM. I authorize GOHM to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from GOHM by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to GOHM. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of GOHM's Privacy Notice. _____ (Initials)

Signature of Responsible Party: X_____ **Date:** _____

Printed Name of Responsible Party: X_____ **Date:** _____