Grant County Health Department-Nursing

Patient Registration

Today's Date: ____/____/_____
DD MM YYYY

Patient Name: _____, _____ _____
Last Name (Family Name) *First Name (Given Name)* *Middle Name*

Alias Name: _____, _____ _____
Last *First* *Middle*

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone - Home: _____ Cell: _____ Work: _____

E-mail: _____

Patient Gender: *Male / Female (Circle One)* Date of Birth: ____/____/_____ *DD MM YYYY* Age: _____ *Days / Months / Years (Circle One)*

Birth State: _____ Birth Country: _____

Patient's Race/Ethnicity: *African American / Asian/Nat. Hawaiian, Pacific Islander / Latino / Multi-racial / White / Other:* _____
---------- *(Circle One)* ----------

Hispanic Origin: Hispanic / Non-Hispanic / Unknown (Circle One)

School: _____

Guardian 1 Last Name: _____ First Name: _____

Guardian 2 Last Name: _____ First Name: _____

Mother's Maiden Name: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Family Physician *(if applicable)*: _____

Emergency Contact *(Other than Spouse)*: _____

Relationship to Patient: _____ Phone Number: _____

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PATIENT INSURANCE: Does the patient have, or is the patient covered by health insurance? *(Circle One)* Yes No

1. **PRIMARY** Insurance Company Name:_____

   Address _____

   City: _____ State: _____ Zip: _____

   Policy Number: _____ Group Number _____

   Policy Holder *(Insured's Name)*: _____ Policy Holder Date of Birth ____/____/_____
   MM DD YYYY

   What relationship is Policy Holder to the Patient? *(Circle One)*: Spouse Child Self Other: _____

   Is policy through Employer? If Yes, Employer's Name: _____

   Effective Date of Policy:_____ Work Phone: _____

2. **SECONDARY** Insurance Company Name: _____

   Address _____

   City: _____ State: _____ Zip: _____

   Policy Number: _____ Group Number _____

   Policy Holder (Insured's Name): _____ Policy Holder Date of Birth ____/____/_____
   MM DD YYYY

   What relationship is Policy Holder to the Patient? *(Circle One)* Spouse Child Self Other:_____

   Is policy through Employer? If Yes, Employer's Name: _____

   Effective Date of Policy:_____ Work Phone: _____

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to Grant County Health Dept. for any services furnished to me by the Grant County Health Dept. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

My signature indicates that all information provided above is true and accurate:

_____ _____
Signature of Patient or Legal Representative Date

If patient is under the age of 18:

Full Name of Parent or Legal Representative: _____

Address if different: _____

City _____State _____ Zip _____ Day Phone _____