grand river Health
exceptional healthcare locally

Patient Information

Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____ Physical Address:_____

City:_____ State:_____ Zip:_____ Sex: M F

Primary Phone:_____ Secondary Phone:_____ Work Phone:_____

Date of Birth:_____ Social Security #:_____ Religious Pref: _____

Marital Status: Single Married Widowed Divorced Patient's Maiden Name:_____

Mother's First Name: (Security Question)_____ Primary Care Physician:_____

Patient's Email Address for Follow My Health Patient Portal:_____

If necessary to contact you for follow up care or to confirm appointments, may we leave a message? Yes_____ No_____

Patient Employment Information or Parent/ Guardian Employment Information

Employer Name:_____ Address:_____

Phone:_____ Occupation: _____ Full or Part time

Guarantor (Person financially responsible to receive statements)

Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____ City/State:_____ Zip:_____

Date of Birth:_____ Social Security #:_____ Relationship to Patient: _____

Phone:_____ Work:_____ Cell:_____

Emergency Contact or Next of Kin

Name:_____ Relationship to Patient:_____

Address:_____ City/State:_____ Zip: _____

Phone:_____ Cell:_____ Work:_____

Insurance Information

Insurance Company:_____ Policy #:_____ Group#:_____

Subscriber:_____ Date of Birth:_____ Social Security #:_____

Address:_____ Phone #:_____ Relationship to Patient:_____

I hereby authorize Grand River Clinics to furnish information to insurance carriers concerning my illness and treatments. I also assign to the Provider all payments for medical services rendered. I know and understand that any payments rejected by my insurance are between the company and myself, and that I am responsible for any amount not covered by my insurance. I authorize GRHD, its employees, agents and providers to provide me medical treatment in ways they judge beneficial to me, including follow up treatment, testing, and examinations. No guarantee has been made to me about the outcome of this treatment.

Ethnicity
___Hispanic/Latino
___Non-Latino/Hispanic
___Other
___Prefer not to answer

Race
___White ___American Indian/Alaska Native
___Hispanic ___Black/African American
___Asian ___Native Hawaiian/Pacific Islander
___Other ___Prefer not to answer

Primary Language
___English
___Spanish
___American Sign Language
___Other
___Prefer not to answer

Signature:_____ Date:_____