

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: _____