Gordon MEMORIAL HEALTH SERVICES
"Professionals Who Care, Right Here At Home"

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____ Date of Birth _____
LAST FIRST MIDDLE INITIAL

Address _____
STREET CITY STATE ZIP CODE

Phone Number _____ _____ Sex (circle one): Male Female Other_____
HOME CELL

Social Security Number _____ Marital Status: S M D W Other_____

Employer Name _____ Employer Phone _____

Employer Address _____

Race: African American Asian Caucasian Hispanic American Indian Native Hawaiian Other

Ethnicity: Hispanic Not Hispanic Other Preferred Language: _____

Religion: Baptist Catholic Methodist Lutheran Presbyterian Jehovah's Witness Other: _____

Do you have an Advance Directive? Y N If yes, Do we have a copy on file? Y N

Email Address: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Emergency Contact Address: _____
STREET CITY STATE ZIP CODE

Emergency Contact Phone: _____ Secondary Phone: _____

Relationship to Patient: _____

RESPONSILBE PARTY INFORMATION

Responsible Party (must be 19 or older)

Name _____Social Security Number _____
LAST FIRST MIDDLE INITIAL

Address _____
STREET CITY STATE ZIP CODE

Phone _____ _____ Relationship to Patient _____
HOME CELL

Employer Name _____ Employer Phone _____

INSURANCE INFORMATION

Please have insurance cards readily available to copy*

Primary Insurance

Company Name _____ Policy Number _____

Policy Holder Name _____ Policy Holders' Date of Birth _____

Effective Date _____ Group Number _____

Secondary Insurance

Company Name _____ Policy Number _____

Policy Holder Name _____Policy Holders' Date of Birth _____

Effective Date _____ Group Number _____

I certify that the information I've provided is both accurate and correct to the best of my knowledge. I understand that inaccurate information may result in non-payment by my insurance company, and I may be responsible for all charged incurred.

Signature: _____ Date: _____