YourTown Health

PATIENT REGISTRATION 2024

Patient Name: _____ **Social Security Number**: _____-_____-_____
Date of Birth: _____/_____/_____ **Marital Status:** Single___ Married____ Divorced___ Widow___ **Veteran?** Yes No
Seasonal? Yes No Migrant? Yes No Homeless? Yes No Limited English Proficiency? Yes No

What sex were you assigned at birth? Male_____ Female _____
Sexual Orientation (circle all that apply): Lesbian or Gay Heterosexual (or straight) Bisexual
Other Don't Know Choose Not To Disclose
What is your current gender identity? (Check all that apply) Male _____ Female _____ Transgender Male/Trans Man/FTM ____
Transgender Female/Trans Woman/MTF _____ Genderqueer _____ Additional Category _____
What pronouns do you prefer? he/him ____ she/her ____ they/them _____ other: _____

Address_____Zip Code _____County: _____
Home Phone (_____) _____ **Cell Phone** (_____) _____
Email Address _____ [ ] **I wish to sign up for the Patient Portal**
[ ] Do not have email [ ] Will not disclose email
Race (circle one): Asian American Indian/Alaskan Native Black/African American Native Hawaiian
Other Pacific Islander White More Than One Race Decline to Specify
Ethnicity (circle one): Hispanic / Latino Not Hispanic / Latino Decline to Specify
Preferred Language (circle one): English Spanish Other: _____

Employer Name _____ Phone Number _____

Primary Care Physician _____ Phone Number _____
How did you hear about our Practice? _____
Do you have medical or dental insurance? Yes _____ No _____ If yes, please present your insurance card.

Person responsible for bill or parent (Complete section only if different from patient)
Guarantor Name _____ Social Security Number _____-_____-_____
Relationship to Patient :(circle one) Self Spouse Parent Date of birth of Guarantor _____/_____/_____
Address_____Phone Number_____
Employer Name_____Address_____
Total Household Income: Less than $30,000 _____ $30,001 - $ 45,000 _____ $45,001 - $ 60,000 _____
Greater than $60,000 _____ Choose not to disclose _____

Emergency Contacts (list 2)
Name_____ Relationship _____
Home Phone _____ Cell Phone _____
Name _____ Relationship _____
Home Phone _____ Cell Phone _____
Georgia Advanced Directive [ ] Yes [ ] No
Preferred Pharmacy _____ **Phone Number** _____

First Insurance Information
Plan Name _____ ID Number _____
Address _____ Group Number _____
Policy Holder _____ Effective Date _____
Policy Holder's Social Security Number_____
Second Insurance Information
Plan Name _____ ID Number _____
Address _____ Group Number _____
Policy Holder _____ Effective Date_____
Policy Holder's Social Security Number_____
Is Your visit due to a job-related injury or automobile accident? YES_____ NO _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS BILL TO MY INSURANCE COMPANY, AND REQUEST PAYMENT OF BENEFITS TO PALMETTO HEALTH COUNCIL, INC. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT WHETHER OR NOT COVERED BY INSURANCE. I ALSO AUTHORIZE THE HEALTHCARE STAFF TO PERFORM ALL NECESSARY SERVICES REQUIRED FOR TREATMENT.

Signature_____Date_____