Greeley County Health Services

Serve with Compassion & Excellence

REGISTRATION FORM (AGE 19 AND UP)

Patient's Name _____ **Birthdate** _____
(First, middle, and last name as it appears on insurance cards)

SSN #:_____ **Sex**: Male / Female **Primary Language:** _____

Race: White / Asian / Black / Hispanic / More than One / Other
Ethnicity: Hispanic / Non-Hispanic / Unknown
Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed
Active Military / Veteran: □ Yes □ No
Agriculture worker / Farmer / Rancher: □ Yes □ No
Are you currently homeless or living in temporary housing: □ Yes □ No

Home Address : _____
ADDRESS CITY/STATE/ ZIP

Home Phone (_____)_____ **Cell Phone** (_____)_____

Email address _____ **Employer:** _____

Phone # _____**Ext.**_____ **Occupation:** _____

Spouse_____ **Birthdate** _____ **SSN #** _____
(First, middle, and last name)

Home / Cell Phone # _____ **Email address** _____

Employer _____ **Phone #** _____

Emergency Contact 1:_____ **Relation to Patient** _____
(Other than spouse) (First, middle, and last name)

Lives with patient? Yes / No **Birthdate** _____ **Home Phone #** _____

Cell Phone # _____ **Email address** _____

Emergency Contact 2:_____ **Relation to Patient** _____
(Other than spouse) (First, middle, and last name)

Lives with patient? Yes / No **Birthdate** _____ **Home Phone #** _____

Cell Phone # _____ **Email address** _____

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INSURANCE INFORMATION

(GIVE INSURANCE CARD(S) TO RECEPTIONIST)

See scanned insurance card _____

Primary Insurance Company _____ Group # _____

Subscriber's Name _____ DOB:_____ID # _____
(First, middle, and last name as it appears on insurance cards)

Employer's Name _____

Secondary Insurance Company _____ Group # _____

Subscriber's Name _____DOB:_____ ID # _____
(First, middle, and last name as it appears on insurance cards)

Employer's Name _____

Patient or Personal Representative Signature: _____

Date: _____