WELCOME

Green River Medical Center

Is committed to provide 100% access to quality, safe, professional health services for all citizens of our community and surrounding area without regard to race, religion, age, gender, or ability to pay. Our goal is improved physical and emotional wellness for all.

PATIENT INFORMATION:

PATIENT NAME : (Last) (First) (Middle)			
ADDRESS: P.O. Box (Street Address)			
CITY:	**STATE:**	**ZIP:**	
HOME PHONE: ( )	**BIRTHDATE:**	**AGE:**	
☐ **BY CHECKING THIS BOX I DO NOT WANT TO RECEIVE AUTOMATED TELEPHONE CALLS OR TEXTS**		**CELL. NUMBER:** ( )	
SEX: ☐ M ☐ F	**SS#**	☐ **SINGLE** ☐ **MARRIED** ☐ **OTHER**	
EMPLOYER :	**OCCUPATION:**		
EMPLOYER ADDRESS :			
WORK PHONE : ( )	**OTHER PHONE:** ( )		
EMAIL :			

PAYMENT RESPONSIBILITY:

IS THE PATIENT COVERED BY HEALTH INSURANCE? **YES** ☐ **NO** ☐ **NOT SURE** ☐			
IF THE PATIENT IS NOT COVERRED BY ANY INSURANCES OR HEALTHCARE PLAN , THE RESPONSIBLE PERSON ACCEPTS RESPONSIBILITY FOR PAYMENT OF THIS ACCOUNT. PLEASE DISCUSS ARRANGEMENTS OR DISCOUNT ELIGIBILITY WITH GREEN RIVER MEDICAL CENTER STAFF. **PLEASE DO NOT ALLOW LACK OF INSURANCES OR FUNDS TO ADVERSELY EFFECT THE HEALTH OF THE PATIENT.**			
NAME AND ADDRESS OF RESPONSIBLE PERSON OR POLICY HOLDER:			
RELATIONSHIP TO PATIENT : ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____			
BIRTHDATE:	**ID#**	**GROUP#**	
INSURANCE COMPANY :			
IS PATIENT COVERED BY AN ADDITIONAL INSURANCE COMPANY ? ☐ **YES** ☐ **NO** ☐ **NOT SURE**			
NAME OF POLICY HOLDER :		**BIRTHDATE:**	
INSURANCE COMPANY :	**ID#**	**GROUP#**	

PLEASE CONTINUE THIS FORM ON THE BACK

EMERGENCY CONTACT: ☐ SPOUSE ☐ PARENT ☐ OTHER

NAME : (LAST) (FIRST) (MIDDLE)		
ADDRESS: P.O. BOX (Street Address)		
CITY:	**STATE :**	**ZIP:**
HOME PHONE : ( )	**BIRTHDATE:**	**AGE:**
SEX: ☐ M ☐ F **SS#**	☐ **SINGLE** ☐ **MARRIED** ☐ **OTHER**	
EMPLOYER:	**OCCUPATION:**	
EMPLOYER ADDRESS:		
WORK PHONE :( )	**OTHER PHONE:**( )	

PATIENT SERVICES: (OPTIONAL)

PATIENT RACE : ☐ **CAUCASIAN** ☐ **HISPANIC** ☐ **AFRICAN AMERICAN** ☐ **ASIAN** ☐ **OTHER**_____

WOULD THE PATIENT PREFER HEALTHCARE SERVICES IN ANOTHER LANGUAGE? ☐ YES ☐ NO

WOULD THE PATIENT LIKE INFORMATION ABOUT PAYMENT OPTIONS AND OUR SLIDING FEE COST DISCOUNT PROGRAM ?
☐ YES ☐ NO ☐ NOT SURE

PREFERRED PROVIDER: _____ Shannon Thurston, PA-C _____ Kim McFarlane, PA-C

NAME OF PREFERRED PHARMACY

FIRST CHOICE: _____ **SECOND CHOICE:** _____

HEALTH LITERACY

HOW OFTEN DO YOU NEED TO HAVE SOMEONE HELP YOU READ INSTRUCTIONS, PAMPHLETS, OR WRITTEN MATERIAL FROM YOUR DOCTOR OR PHARMACY?

____ NEVER ____ SOMETIMES ____ RARELY ____ OFTEN ____ ALWAYS

DO YOU HAVE DIFFICULTY: ____ HEARING ____SEEING ____WITH ENGLISH ____OTHER _____

PLEASE SIGN HERE THAT ABOVE INFORMATION IS CORRECT:

X_____**DATE:**_____

(OFICE USE ONLY) REVISION DATE 05/04/2016