REGISTRATION FORM

(Please Print)

CARROLL: (502) 732-1082
GALLATIN: (859) 567-1591
OWEN: (502) 484-2117
Behavioral Health (502) 484-2595
Dental Clinic (502) 484-5888

PATIENT INFORMATION

Last Name	First	Middle Initial	Social Security Number	Birth Date / /

Mailing Address

City/State

Zip

Sex assigned at birth (check one)
- ○ Male
- ○ Female

Physical Address (if different from mailing address above)

City/State/Zip

Home Phone ( ) -

Cell Phone ( ) -

○ Check if the same as home phone

Email Address

Preferred Contact Method: (check one)
- ○ Cell phone
- ○ Home phone
- ○ No contact
- ○ Regular mail

Gender Identity: (check one)
- ○ Male
- ○ Female
- ○ Transgender Male/Female-to-Male
- ○ Transgender Female/Male-to Female
- ○ Genderqueer, neither exclusively Male or Female
- ○ Decline to Answer
- ○ Other_____

Sexual Orientation: (check one)
- ○ Straight or heterosexual
- ○ Lesbian, Gay, or homosexual
- ○ Bisexual
- ○ Something else
- ○ Do not know
- ○ Decline to Answer
- ○ Other_____

Race: (check **all that apply**)
- ○ White
- ○ Black
- ○ Pacific Islander
- ○ Asian
- ○ Native Hawaiian
- ○ American Indian/Alaska Native
- ○ Other _____

Ethnicity: (check one)
- ○ Hispanic
- ○ Non-Hispanic

Preferred Language: (check one)
- ○ English ○ Spanish
- ○ Sign Language (ASL)
- ○ Other _____

Marital Status: (check one)
- ○ Single ○ Married
- ○ Divorced ○ Widow
- ○ Separated

Are you Homeless: (check one)
- ○ Yes ○ No

Are you a Veteran: (check one)
- ○ Yes ○ No

Understands English: (check one)
- ○ English is primary language
- ○ Other primary language with interpreter used
- ○ Other primary language used

○ **Interpreter needed for visit** (inform receptionist)

Migrant Worker/Dependent: (check one)
- ○ Dependent of Migrant/ Seasonal Worker
- ○ Migrant/Seasonal Worker
- ○ None

Pharmacy Name:

Pharmacy Location/Phone number:

Responsible Party/Guardian Name:

Responsible Party/Guardian Phone:

INSURANCE INFORMATION (Please give your insurance card and proof of ID to the receptionist)

Insurance Company Name: **Policy No:** **Group No:** **Copay:**

Subscriber Name: **Subscriber SSN:** **Relationship:**

RESPONSIBLE PARTY INFORMATION

Person responsible for bill: **Birth Date:** **Address, if different from above:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): **Relationship to patient:** **Phone No:**

_____ _____ _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and for Triad Health Systems, Inc. and/or my Insurance Company to release any information required to process my claim(s). I understand that I am financially responsible for any balance.

_____ _____

Patient/Legal Representative/Guardian Signature: Date:

____ **Check for Behavioral Health Services**