REGISTRATION FORM
(Please Print and use **BLACK INK ONLY**)

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

TRIAD Health Systems

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:** **Subscriber DOB:**

RESPONSIBLE PARTY INFORMATION

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

IN CASE OF EMERGENCY

Name of local friend or relative to contact in case of emergency: **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). understand that I am financially responsible for any balance.

_____ _____
Patient/Legal Representative/Guardian Signature: **Date:**

OFFICE USE ONLY:
Data entered by (signature): _____
(Check all Systems that apply)
Entered into System: __**IMS** __**Credible** __**Dentrix**