Patient Registration

PATIENT INFORMATION

Last Name:_____First Name:_____MI:_____ DOB: _____ /_____ /_____
Mailing Address: _____ Social Sec #:_____
City/State/Zip: _____ Sex: ☐M ☐F ☐Other
Marital Status: ☐Single ☐Married ☐Divorced ☐Other Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino
Employer: _____ Occupation: _____

CONTACT INFO AND PREFERENCES

Preferred Language: _____ Referring Provider: _____
Preferred Pharmacy: _____ Other physicians you see: _____
Preferred Lab: _____ Preferred Imaging: _____
Home #: _____ Cell #: _____Work #: _____
OK to leave detailed message: ☐Home ☐Cell ☐Work Email Address: _____
I would like to receive automated notifications via: ☐Phone ☐Text ☐Email ☐None

Emergency Contact: _____ Relationship: _____ Ph. #: _____

GBMDCC is authorized to discuss my medical condition with the following individual:
Name/Relationship: _____Ph.#: _____ ☐Medical ☐Billing ☐Scheduling

INSURANCE INFORMATION (include a copy of your insurance cards)

Primary Insurance:_____ Secondary Insurance: _____
ID #:_____ ID#:_____
Group: _____ Group: _____
Policy Holder: _____ Policy Holder: _____
Relationship to Insured: _____ Relationship to Insured: _____
Policy Holder's DOB: _____ Policy Holder's DOB: _____
Policy Holder's SSN: _____ Policy Holder's SSN: _____

I consent to receive automated phone call or text message for appointment reminders on mobile phone: Yes No

I consent to my medication history being obtained automatically from pharmacy benefit managers (PBMs): Yes No

I consent to record sharing between Glacier Bay Medical and my other providers who also use Athena Health: Yes No

By signing below, I understand that I am ultimately responsible for any charges, regardless of insurance coverage. I will update this office on any changes in my contact or insurance information during the course of billing and treatment.
I authorize this practice to release any necessary information acquired during the course of my treatment to process insurance claims and authorize payment directly to the physician/nurse practitioner. Protected health information may be disclosed to another covered entity for select health care operations, such as: payment activities, treatment, quality assessment activities, and other purposes. I may request a copy of the Notice of Privacy Policy. I understand the organized health care arrangement has the right to change this notice at any time and I may obtain a current copy by contacting this office.

Signature: _____ **Date:** _____/_____/_____

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