Grand River Clinics
exceptional healthcare, locally

Patient Information

Last Name:_____**First:**_____**MI:**_____

Physical Address:_____**Mailing Address:**_____

City:_____**State:**_____**Zip:**_____**Primary Phone #:**_____

Secondary #:_____**Work #:**_____

Date of Birth:_____**Sex:**_____**Social Security #:**_____

Employer Name:_____**City:**_____**Full or Part time:**_____

Married:_____**Single:**_____**Widowed:**_____**Divorced:**_____

Emergency Contact or Next of Kin Name: _____**Relationship**_____
Phone#:_____**Cell#:**_____**Work#:**_____
Address:_____**City/State:**_____**Zip:**_____

If necessary to contact you for follow up care or to confirm appointments, may we leave a message? Yes _____No_____

Guarantor:
Last Name:_____**First Name:**_____
(Person financially responsible to receive statements)
Guarantor Address:_____**City/State:**_____**Zip:**_____

Date of Birth:_____**Social Security#:**_____**Relationship:**_____

Phone#:_____**Work#:**_____**Marital Status:**_____

Cell#:_____**Employer Name:**_____

Insurance Information:
Insurance Company:_____ **Policy#:**_____
Group#:_____
Subscriber:_____**Subscriber's Relationship to Patient:**_____
Subscriber's DOB:_____**Subscriber's Social Security#:**_____

I hereby authorize Grand River Clinics to furnish information to insurance carriers concerning my illness and treatments. I also assign to the Provider all payments for medical services rendered. I know and understand that any payments rejected by my insurance are between the company and myself, and that I am responsible for any amount not covered by my insurance.

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Latino/Hispanic
- ☐ Prefer not to Answer

Race
- ☐ White
- ☐ Hispanic
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ Prefer not to Answer

Primary Language
- ☐ English
- ☐ Spanish
- ☐ American Sign Language
- ☐ Other _____
- ☐ Prefer not to Answer

Signature:_____**Date:**_____