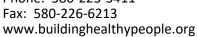
Good Shepherd - 12th Street

20 12th Ave. NW Ardmore, OK 73401 Phone: 580-223-3411 Fax: 580-226-6213





Good Shepherd - Walnut Drive

1104 Walnut Drive Ardmore, OK 73401 Phone: 580-226-0543 Fax: 580-226-2284 www.buildinghealthypeople.org

ALL SECTIONS MUST BE FILLED IN - NO BLANK AREAS

PATIENT INFORMATION					
Full Name (Last, First, Middle):					
Date of Birth (MM/DD/YYYY): Social Security Number:	Mother's Maiden Name:				
Mailing Address (Street, City, State, Zip, County):					
Physical Address (Street, City, State, Zip):					
Primary Phone: Mobile Home Phone: () Work Other ()	Mobile Home Phone: Mobile Home Work Other () Work Other				
Email: Contact Preference: Home Work Mobile Mail Portal					
Primary Language: Do you	uneed a translator? Y / N Ethnicity: Hispanic or Latino				
Race: Other: Declined to Answe	☐ White ☐ Asian ☐ Not Hispanic or Latino				
Marital Status: Single Divorced Family members supported by income: Adults: Children: Married Widowed					
SEXUAL ORII	ENTATION / GENDER				
What is your sexual orientation? Straight (not lesbian or gay) Lesbian or Gay Bisexual Declined to Answer					
What is your gender? Male Female Transgender Declined to Answer He / Him / His She / Her / Hers Other:					
Gender (at birth): Homebound: Male Female Declined Yes No	Agricultural Worker: Homeless: Yes No Yes No				
School Based Health Center Patient: Yes No	Veteran: Public Housing: Public Housing:				
HOW DID YOU HEAR ABOUT OUR SERVICES? (choose all that apply)					
Advertising PCP Specialist Word of Mouth Patient Hospital Other:					
EMERGENCY CONTACT					
Patient's relation to contact: Parent Child Spouse Other:					
Primary Phone: Mobile Home Phone: () Work Other ()	Mobile Home Phone: Mobile Home Work Other () Work Other				
Next of Kin (Name, Relationship): Phone: Work Other					
EMPLOYMENT INFORMATION					
Employer Name:	Employer Phone Number:				
Occupation:	Usual Industry:				

RESPONSIBLE PARTY INFORMATION						
Full Name (Last, First, Middle):						
Date of Birth (MM/DD/YYYY):	Patient's relation to responsible party: Self Child Spouse Other:					
Address (Street, City, State, Zip):						
Primary Phone: Mobile Home Phone: () Work Other ()	Mobile Home Work Other	Phone:	Mobile Work	Home Other		
INSURANCE INFORMATION						
PLEASE PROVIDE A COPY OF INSURANCE CARDS AND DRIVER'S LICENSE						
Primary Insurance Company:	Effective Date:					
Claim Address (Street, City, State, Zip):						
ID Number:	Group Number:					
Cardholder Name:	Date of Birth (MM/DD/	YYYY):	Social Security Number:			
Cardholder Address (Street, City, State, Zip):						
Cardholder Employer:						
INSURANCE I	INFORMATION CON	T.				
condary Insurance Company:		Effective Date:				
Claim Address (Street, City, State, Zip):						
ID Number:	Group Number:					
Cardholder Name:	Date of Birth (MM/DD/YYYY):		Social Security Number:			
Cardholder Address (Street, City, State, Zip):						
Cardholder Employer:						
PREFERRED PHARMACY						
Pharmacy Name:	Phone Number:		City:	State:		

I hereby state that the above information is true and correct to the best of my knowledge. I authorize the above-named practice to release any information acquired during my treatment to my insurance company, employer, physicians, institutions, or thirdparty payers, as required for certain claims filed. In addition, I have reviewed the Notice of Privacy Practice and understand that I may receive a printed copy upon verbal or written request. Furthermore, I authorize direct payment to be made to the above-named practice for any and all medical services rendered. I understand if any service charges are not covered by my insurance, I will be solely responsible for those fees.