Good Shepherd - 12th Street
20 12th Ave. NW
Ardmore, OK 73401
Phone: 580-223-3411
Fax: 580-226-6213
www.buildinghealthypeople.org

GOOD SHEPHERD
community clinic, inc.

building healthy people

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 ☐ Work ☐ Other | Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ Other | Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ Other

Email: | Contact Preference: ☐ Home ☐ Work ☐ Mobile ☐ Mail ☐ Portal

Primary Language: | Do you need a translator? Y / N | Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Answer

Race: ☐ African American ☐ Native American ☐ White ☐ Asian ☐ Other:_____ ☐ Declined to Answer

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed | Family members supported by income: Adults: Children:

SEXUAL ORIENTATION / 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

Preferred pronoun:
☐ He / Him / His ☐ She / Her / Hers ☐ Other: _____

Gender (at birth): ☐ Male ☐ Female ☐ Declined | Homebound: ☐ Yes ☐ No | Agricultural Worker: ☐ Yes ☐ No | Homeless: ☐ Yes ☐ No

School Based Health Center Patient: ☐ Yes ☐ No | Veteran: ☐ Yes ☐ No | Public Housing: ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT OUR SERVICES? (choose all that apply)

☐ Advertising ☐ PCP ☐ Specialist ☐ Word of Mouth ☐ Patient ☐ Hospital ☐ Other: _____

EMERGENCY CONTACT

Full Name:

Patient's relation to contact:
☐ Parent ☐ Child ☐ Spouse ☐ Other:_____

Primary Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ Other | Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ Other | Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ Other

Next of Kin (Name, Relationship): | Phone: ( ) ☐ Mobile ☐ Home ☐ 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 ☐ Work ☐ Other	Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ Other	Phone: ( ) ☐ Mobile ☐ Home ☐ Work ☐ 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 INFORMATION CONT.

Secondary 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.

Signature of Patient / Parent / Legal Guardian **Printed Name** **Date**