GRAHAM HEALTH CENTER
OAKLAND UNIVERSITY
PATIENT REGISTRATION FORM

PATIENT INFORMATION			
NAME (Last, first, middle initial)	University ID# (Grizzly)	Sex M F	Birth Date
Address	City/State	Zip	Cell Number/Home Number
Patient Email	Emergency Contact Name	Relationship	Phone #

INSURANCE INFORMATION ____NONE ____ NOT USING _____ GHC DOES NOT participate with my ins			
Name of Insurance Company	Name of Policy Holder	Relationship to Patient	Contract/Group #
Address of policy holder	City	State	Zip
Phone number of policy holder	Date of Birth for policy holder		

I understand that

- I will be responsible for any amounts that are not covered by my insurance
- I understand my insurance may pay for all, some or none of my care
- It is my responsibility to understand the amount of care my insurance will cover and I have been advised to call my insurance company to verify coverage if I have any questions. It is not GHC responsibility to understand my insurance coverage.
- Any amounts outstanding may be billed to my Oakland University student account.

If I do not have insurance

- Additional charges for laboratory tests may apply if the initial result is abnormal
- Additional charges will be placed on my student account

AUTHORIZATION: I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to myself under supervision of the nurse practitioners or physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any, including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any, and records of a communicable disease, if any; to my insurance company for the purpose of payment of my bill and to my health care provider for continuity of care. I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance. I understand that any amounts outstanding may be billed to my Oakland University student account.

- I understand that if any employee, physician, or agent of Oakland University sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I give permission for Graham Health Center to contact me by email ___ YES ___ NO

Signature: _____ Date: _____