



# Grand Traverse Internal and Family Medicine, P.C.

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## Patient Registration

### Patient Information

Patient Name:

Mailing Address:

Home Phone:

Cell Phone:

Work Phone:

Primary Care Provider:

Date of Birth:

**Social Security Number:**

Sex:        M        F        Transgender

Email Address:

Marital Status:

Primary Language:        *Translator? Y N*

Race: American Indian or Alaska Native    Asian    Native Hawaiian    Black or African American  
White    Hispanic    Other Race    Other Pacific Islander    Decline to Report

Ethnicity: Hispanic    Non-Hispanic    Decline to Report

### Insurance Information\*

**Primary Insurance**

Phone Number

Subscriber Name:

Subscriber ID:

Date of Birth:

Group Number:

**Secondary Insurance:**

Phone Number:

Subscriber Name:

Subscriber ID:

Date of Birth:

Group Number:

*\*If you are covered under another person's insurance, please notify a staff member.*

### Other Information

Employer Name:

Phone Number:

Employment Status:    Full    Part    Self    Retired    Other: \_\_\_\_\_

Emergency Contact Name:

Phone Number:

Relationship:    Spouse    Parent    Sibling    Child    Other: \_\_\_\_\_

Retail Pharmacy Name:

Pharmacy Number:

Mail Order Pharmacy:

Pharmacy Number: