GNR PUBLIC HEALTH
GWINNETT, NEWTON AND ROCKDALE
HEALTHY. PROTECTED. PREPARED.
www.gnrhealth.com

PATIENT REGISTRATION AND INCOME INFORMATION

Please print and fill out completely:

Last Name _____ First Name _____ Preferred Name _____ Middle Initial___
Maiden/Former Name _____ Date of Birth ___/____/_____ Age _____
Sex Assigned at Birth ☐ Female ☐ Male ☐Intersex Gender Identity: ☐ Female ☐ Male ☐ Other_____
Georgia Resident: ☐Yes ☐ No County _____
Street, House or Apt. #_____ City _____ Zip code _____
Mailing Address (if different) _____
Email address: _____ Day Phone _____ Mobile _____
I can be contacted by (check all that apply): ☐Mail ☐Email ☐Mobile Can we leave a voicemail? ☐Yes ☐No
Emergency Contact: If less than 18 years old, name of Parent/ Guardian and Phone #
Name _____Relationship _____ Phone # _____

Racial Group- You can select more than one.

☐African American/Black
☐Asian
☐Caucasian/White
☐Native American/ Native Alaskan
☐Native Hawaiian/ Pacific Islander
☐Other

Ethnic Group

☐Hispanic
☐Non-Hispanic

Marital Status

☐Married ☐Widowed
☐Divorced ☐Single
☐Separated

Do you have health insurance, Medicaid, or Medicare? No ☐ Yes ☐
Health Insurance/Medicaid/Medicare Provider: _____ **ID#** _____
Primary Policyholder Name: _____ **Primary Policyholder DOB:** _____
Were you referred by TANF? No ☐ Yes ☐ Do you participate in WIC? No ☐ Yes ☐

Service fees for Family Planning, Women's Health, and STD are set on a sliding scale based on gross income and family size. Patients over the age of 19 will be asked to prove income and residency, in order to qualify for a reduced price. Eligibility for BCCP is based on gross income and family size.
List all members in household who support you or who are supported by you, including yourself. List all income, including child support, alimony, unemployment, SSI, etc.

NAME	AGE	DOB	RELATIONSHIP	GENDER	INCOME BEFORE TAXES
SELF					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr
					$ wk/mo/yr

I certify that the above information is true and correct. _____ _____
Patient Signature Date
I did not provide proof of income and/or residency and agree to pay 100% of my costs. _____ _____

INTAKE USE ONLY
Total # people in household_____ Total Household Income $ _____mo/yr FP/WH/STD % pay _____ BCCP eligible_____

_____ _____
Intake Signature Date

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